Cataloging Public Health Expenditures in Idaho

Report by
University of Minnesota
State Health Access Data Assistance Center

for

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Idaho's Health Care Costs and Options to Improve Health Care Access

Report on Task 1: Cataloging Public Health Expenditures in Idaho

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- Idaho Primary Care Association
- Idaho Association of Counties
- Idaho Sheriffs' Association
- Ada County Sheriff's Office

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EXECUTIVE SUMMARY

This report is one out of a series of reports prepared for the Idaho Office of Performance Evaluations (OPE), the Joint Legislative Oversight Committee, and the Idaho Health Care Task Force as part of the project, "Idaho's Health Care Costs and Options to Improve Health Care Access." The Idaho Health Care Task Force requested that this project be conducted to generate information on health care spending, the uninsured, and various policy approaches as the Task Force considers options for expanding health insurance coverage and health care access in the state. The Idaho Legislature (Senate Bill 1340) appropriated funds for the project in 2006.

This report presents a study of public (i.e., government) health care expenditures in Idaho conducted by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health. The purpose of the study was to systematically collect and organize data on and quantify federal, state, and local government health care expenditures in Idaho between 2002 and 2006. The report covers five broad categories of spending: 1) Medicare, 2) Medicaid/Children's Health Insurance Program (CHIP), 3) public employee health benefits, 4) safety net programs, and 5) other government health care spending. Across these five categories, the report provides detailed expenditure information on 13 programs or spending areas:

- Medicare
- Medicaid/CHIP
- State employee health benefits
- Local government employee health benefits
- County Medical Indigency Program
- State Catastrophic Health Care Cost Program
- Idaho's Individual High Risk Reinsurance Pool
- Community health centers (CHCs)
- Adult corrections health care
- Juvenile corrections health care
- County corrections health care
- Public health services
- State health-care related tax expenditures

Data presented in the report come from program reports and analyses made available by numerous state, local, and private agencies within Idaho as well as national data sources affording state-level data. The expenditures presented in this report were not adjusted for inflation.

The majority of the report is divided into 13 small chapters (typically no more than 10 pages each) providing program-specific information for each of the areas of public health care spending. For each program, we provide a brief summary of the program and present available data on program financing, enrollment, medical and administrative expenditures, and detailed medical expenditures by service category and diagnosis when available. We organize the report by program so that it may serve as a user-friendly reference regarding each area of public health

care spending and help to answer specific questions that arise during continued discussions of health reform in Idaho. It is our hope that the report can be a helpful resource for the Idaho Health Care Task Force and the State Legislature as they consider current patterns of health care spending in the state and reform options to rearrange public resources to expand health coverage and health care services to uninsured residents. We also hope that our experience in conducting this study and the lessons learned from the process can inform future efforts to compile information on health care spending in the state of Idaho.

This Executive Summary aggregates the program-specific data presented throughout the body of the report to provide a broad picture of the distribution and composition of public health care spending in Idaho at the federal, state and local levels as well as public health care spending in Idaho across the five categories of programs. To simplify this summary of results, we focus on available data for the most recent years, 2005 (in the context of Medicare) and 2006 (for all other programs). We attempted to collect data from all programs on a state fiscal year (FY) basis, but some of the programs were not able to furnish data for this time frame and instead provided data for calendar year (CY) or county fiscal year (CFY). It is important to point out that for the purpose of providing an overview of public health care spending in Idaho within this Executive Summary, our aggregation of program-specific data therefore necessitated blending these various time frames. For expenditure information concerning a particular program, we encourage the reader to refer to the relevant program-specific chapter within the report and particularly the bullet points provided under the "Highlights" section at the end of each chapter:

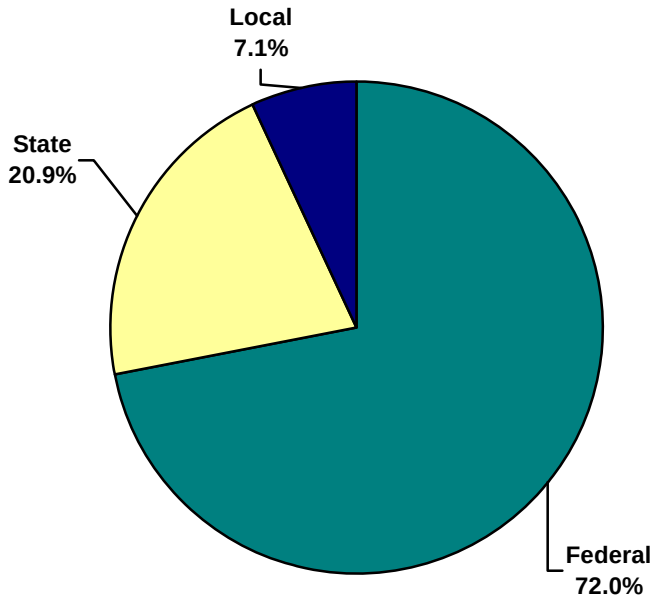
Program	Chapter	Highlights
Medicare	Page 9	Page 13
Medicaid/CHIP	Page 14	Pages 19, 23, 27
State employee health benefits	Page 28	Page 42
Local government employee health benefits	Page 43	Page 52
County Medical Indigency Program	Page 53	Page 57
State Catastrophic Health Care Cost Program	Page 58	Page 62
Idaho's Individual High Risk Reinsurance Pool	Page 64	Page 70
Community health centers (CHCs)	Page 71	Page 79
Adult corrections health care	Page 80	Page 83
Juvenile corrections health care	Page 84	Page 88
County corrections health care	Page 89	Page 94
Public health services	Page 96	Page 106
State health-care related tax expenditures	Page 107	Page 109

Following a summary of findings, this Executive Summary offers recommendations for the compilation of Idaho's public health expenditure data in the future.

Overview of Findings for Idaho

Public Health Care Spending in Idaho by Federal, State, and Local Funds

Public Health Care Spending in Idaho by Government Level (2005)



Total Public Expenditures: $2.6 billion

Notes: Based on the 13 federal, state, and local areas of public health care spending addressed in the full report: Medicare; Medicaid/CHIP; state, county, city, school district employee health benefits; state and county medical indigent care; Idaho's Individual High Risk Reinsurance Pool; community health centers; state adult and juvenile and county corrections health care; public health services; and select health care-related tax expenditures.

- Taking into consideration all of the public programs addressed in this report, public health expenditures in Idaho totaled $2.6 billion in 2005.

- As shown in the figure above, federal funds totaled nearly $1.9 billion and constituted the majority (72.0%) of the $2.6 billion in public health care spending in Idaho in 2005. State dollars supported just over a fifth of public spending ($544.7 million), followed by local government funds ($183.7 million or 7.1%).

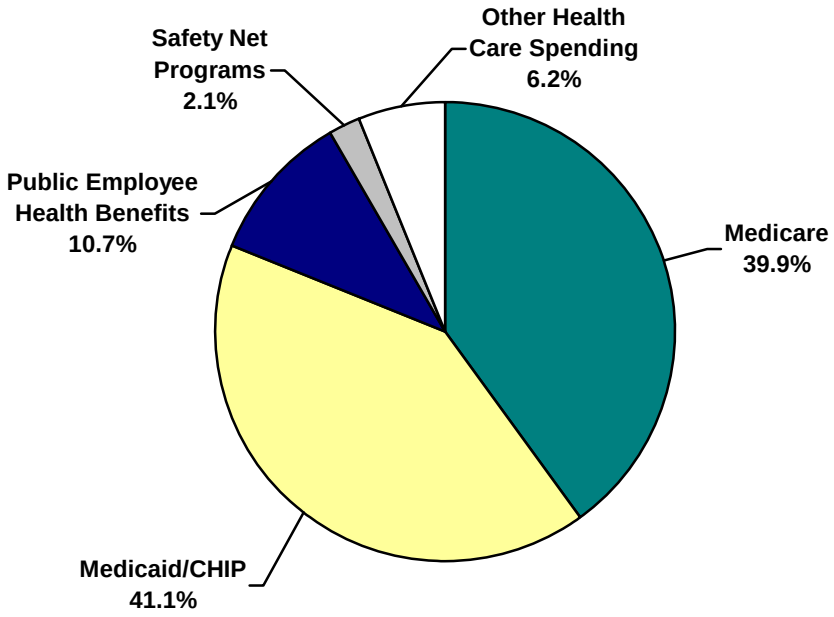
- *Federal funds* supported the following programs in the state: Medicare, Medicaid/CHIP, public health services, and CHCs. In 2005, *just over half (55.4%) of federal public health care spending in Idaho was directed to Medicare*. *Medicaid/CHIP represented another 40.4% of federal spending in the state*. Public health service expenditures and federal grants to CHCs comprised relatively minor shares of federal spending (3.3% and 0.9%, respectively) in Idaho.

- Within Idaho, *state funds* supported Medicaid/CHIP, state employee/retiree health benefits, the state Catastrophic Health Care Cost Program, the high risk reinsurance pool, CHCs, adult and juvenile corrections medical care, public health services, and tax expenditures. In 2006, *over half (56.3%) of state public health care spending was on Medicaid/CHIP, followed by 22.1% for state employee/retiree health benefits and 13.0% for public health services*. The State Catastrophic Program, adult corrections, and tax expenditures on health care-related deductions made up significantly smaller shares of state spending. Juvenile corrections, the Idaho Individual High Risk Reinsurance Pool, and CHCs made up less than 1.0% of state spending on health care in Idaho.

- *Local government funds* were used for local public employee health benefits, the counties' indigent medical indigency programs, county corrections medical care, and CHCs in the state. *The majority (87.6%) of local public health care spending in 2006 was for public employee health benefits*. The county medical indigency program ($16.1 million or 7.9%), county jail medical expenditures ($9.1 million or 4.5%), and CHCs ($0.2 million or < 1.0%) made up the remainder of local public health care spending addressed in this report.

Public Health Care Spending in Idaho across Main Program Areas

Public Health Care Expenditures in Idaho by Spending Category (2005)



Total Public Expenditures: $2.6 billion

Notes: Based on the 13 federal, state, and local areas of public health care spending addressed in the full report organized into five categories: 1) Medicare; 2) Medicaid/CHIP; 3)public employee health benefits (state, county, city, school district employee health benefits); 4) safety net programs (state and county medical indigent care, Idaho's Individual High Risk Reinsurance Pool, community health centers); and 5) other public health care spending (state adult and juvenile and county corrections health care, public health services, and select health care-related tax expenditures).

- This report examines five categories of public health care spending in Idaho: Medicare, Medicaid/CHIP, public employee health benefits, safety net programs, and other public health care expenditures. The figure above shows the distribution of expenditures by spending category.

- Of the $2.6 billion in total public health care spending in Idaho (see figure on previous page), *Medicaid/CHIP ($1.1 billion) and Medicare ($1.0 billion) comprised the majority of public health care spending in the state (each at approximately 40%) in 2005*. Public employee health benefits (state and local combined) amounted to $278.7 million (representing another 10.7%), followed by $161.4 million (or 6.2%) in other public health care spending and $53.9 million (or 2.1%) for safety net programs.

- In 2006, *local employee/retiree benefits (i.e., city, county, and school district) comprised the slight majority of overall public employee/retiree health benefit spending ($178.7 million or 57.8%), whereas state employee benefits cost the state $130.4 million*. The data we obtained for local employee government health benefits overestimate the government's share of these expenditures because the data do not distinguish between the employer's and employee's share of the expenditures. On the other hand, the data likely *underestimate* local government employee health benefit spending in that they do not incorporate administrative expenses associated with the plans.

- Regarding public health care safety net expenditures, *the state Catastrophic Program totaled $20.4 million in 2006, making up 34.8% of the total public health care safety net spending in the state. Considering county medical indigency program expenses ($16.1 million, or 27.4% of total safety net expenditures), medical indigent care totaled $36.5 million, representing over half (62.2%) of the total public health care safety net expenditures in the state*. Although CHCs are a minor player in overall public health care spending in Idaho, they made up another important component of public safety net expenditures. In 2006, their non-patient-related federal and state dollars ($19.8 million) represented a third of total safety net spending. The state's spending on the high risk reinsurance pool ($2.4 million) contributed the smallest share (4.1%) of public safety net spending. (Note: The CHC and high risk pool expenditures presented in this report only pertain to public dollars. Private dollars are not included.)

- Finally, at $143.9 million, *public health services dominated (79.9%) the category of other public health care spending in Idaho in 2006*. Correctional health care (including both state and county, adult and juvenile) resulted in another 14.2% of spending. The majority of corrections medical expenditures were associated with adult state prisoners. Tax expenditures on the health insurance and Medical Savings Account (MSA) deductions contributed another $10.8 million or 6.0% to other public health care spending in Idaho.

Lessons Learned and Recommendations

As the Idaho Health Care Task Force recognized in requesting this study, having up-to-date and complete data on health care expenditures is important for informed decision making by policy makers. It is important to acknowledge, however, that the collection and analysis of such data

can be a time- and resource-intensive process. A key consideration in conducting such an initiative (and maintaining one over time) is to establish policy information needs and priorities. Criteria that may be used to determine the scope of future efforts to compile data on public health expenditures in Idaho include:

- Are there areas of public health care spending with particular relevance to current legislative goals?

- What are the areas of public health care spending over which policy makers have more control? (For example, for state policy makers, is detailed expenditure information concerning state programs the most important?)

- What is each public program's/entity's estimated role in public health care spending? (For example, how important are detailed data on low-expenditure programs such as juvenile corrections health care?)

- Where do key public health expenditure information gaps exist? (For example, if they are of particular interest, local government employee health benefits may warrant further examination.)

- What level of information is needed? (Is there a need for basic information about a broad set of public health care programs or in-depth information for a select set of spending areas?)

- What is the feasibility of obtaining and analyzing certain health care expenditure data?

Yet another consideration in the monitoring of public health care expenditures in Idaho is the availability and accessibility of data. Successful tracking of health care spending requires accurate and efficient information tracking capabilities and obtainable reporting. The availability and accessibility of data from state agencies, local agencies, and private stakeholders should be considered. As indicated several times throughout this report, smaller units of government especially may not be fully automated, may not have easy access to past data, and may not be able to report data in a consistent manner. Further, even when data are available, contractors may have concerns about sharing information that could be considered proprietary in nature. Reporting patterns and requirements of state, local, and private parties should be considered.

A final consideration in the future monitoring of public health care expenditures in Idaho is the scheduling of such an effort. Thorough efforts to catalog state public health care expenditures take time to accomplish. This project collected existing data over a six and ½ month period yet obtaining all requested information still proved difficult for the reasons identified in the report (e.g., the time for program staff to pull data from data warehouses and/or conduct ad hoc analyses, competing demands on program staff, the need for non-public entities to obtain internal approval to furnish data). The time requirements of and information gains from pursuing primary vs. secondary (existing) data should be considered and weighed in light of the state's future information priorities.

INTRODUCTION AND BACKGROUND

At the request of its Health Care Task Force, the Idaho Legislature (Senate Bill 1340) in 2006 appropriated funds for a study on health care expenditures and the uninsured in the State. The bipartisan Joint Legislative Oversight Committee (JLOC), the legislative body responsible for directing all state agency performance evaluations, assigned oversight responsibility for the study to the Idaho Office of Performance Evaluations (OPE).

Conducted in 2007, "Idaho's Health Care Costs and Options to Improve Health Care Access" was a five-part project to compile state-specific data to inform the Health Care Task Force and State Legislature. The five tasks included the following:

1. Catalog public health care expenditures in Idaho
2. Estimate private spending for health care in the state
3. Summarize available data about Idaho's uninsured and insured
4. Compile information on programs in other states to address the uninsured
5. Analyze factors that drive health care costs in Idaho

The State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health was commissioned by OPE to oversee three of these tasks: Tasks 1, 2, and 5. This is the report for Task 1, a study of public health care expenditures in Idaho. Results of Tasks 2 and 5 are available in separate reports (Spencer et al. 2007, Blewett et al. 2007). Mathematica Policy Research, Inc. (MPR) prepared reports on Idaho's uninsured population and programs to address the uninsured (Tasks 3 and 4) (see Taylor and Andrews 2007; Taylor, Fahlman, and Seif 2007).

Study Scope

This report presents information on federal, state, and local public (government) health care expenditures in Idaho, taking into consideration three types of expenditures:

- Direct personal health care (therapeutic goods and services rendered to prevent or treat a specific disease or medical condition), including medical, dental, vision, mental health and substance abuse-related expenditures;
- Administrative expenses associated with the operation of government health care programs; and
- Expenditures for public health services including health promotion and disease prevention and emergency medical services.

Per the interests of state legislators and OPE staff, this report focuses on public health care expenditures for the following public health programs:

- Medicare
- Medicaid
- Children's Health Insurance Program (CHIP)
- State and local public employee health benefits
- State and county indigent medical care

- Idaho Individual High Risk Reinsurance Pool
- Community health centers
- Correctional health care spending
- Public health expenditures
- Tax expenditures on health care-related deductions and credits

Data and Methods

The data presented in this report come from a variety of sources, including national and state-level data sources, as well as program reports and ad hoc data analyses furnished by state and local program staff for the purposes of this study. The expenditures presented in this report were not adjusted for inflation.

Two key national data sources that offer state-level data on public health care spending are the Centers for Medicare and Medicaid Services (CMS) National and State Health Expenditure Accounts and the National Association of State Budget Offices (NASBO) State Health Expenditure Reports. The CMS State Health Accounts calculate total (both public and private) personal health care expenditures for all fifty states. Data are available from 1980 to 2004 and are available by service type (e.g., hospital care). NASBO has issued three State Health Expenditure Reports, providing annual data from 1998-2003. These reports contain state-level data on health spending on programs such as Medicaid/CHIP, state employee health benefits, higher education, state insurance and access expansion, etc. We used the most recent data from the CMS State Health Expenditure Accounts (2004) and trended NASBO data to 2004.[1]

While the CMS State Health Expenditure Accounts and NASBO reports are an important state-level resource, both have limitations. First, NASBO has discontinued the publication of their health care expenditure reports so data do not go beyond 2003. Neither the CMS State Health Accounts nor the NASBO Health Expenditure Reports is comprehensive. The State Health Accounts do not provide information by specific program, and both NASBO and CMS State Health Accounts do not incorporate local government health care spending.

For these reasons, the majority of the data presented in this report come from program reports and analyses made available by relevant state and local agencies in Idaho. Between March and August 2007, we contacted numerous agencies and organizations within the state. We requested information from the Idaho Departments of Administration; Correction; Health and Welfare; Juvenile Corrections; and Medicaid; the Office of the State Controller; and the State Tax Commission. We also contacted two state contract administrators – one for the State Catastrophic Health Care Cost Program (Anderson Nelson Hall and Smith, PA of Idaho Falls) and another for the Idaho Individual High Risk Reinsurance Pool (Ameriben, Inc.). Blue Cross of Idaho and Regence Blue Shield of Idaho provided information about their local public employee plan contracts. Finally, we contacted several other agencies for information: the Idaho Primary Care Association, the Idaho Association of Counties, the Idaho Association of Sheriffs, and Ada County Jail. OPE staff provided key contacts for many of these agencies and organizations.

For all programs, we attempted to collect data for the previous five complete state fiscal years (FY)—i.e., FYs 2002-2006.[2] As relevant, we inquired about funding sources, program enrollment, and medical and administrative expenditures. We also asked for medical expenditures by service type (e.g., hospital care, prescription drugs, mental health, substance abuse) and for the top ten diagnoses in terms of spending. Staff at each agency/organization directed us to program reports or conducted analyses based on available administrative data.

It is important to acknowledge the potential limitations of using agency administrative data for research purposes. The availability and quality of data are impacted by the data collection processes of an agency and its data system and technology to store the data. Data systems may change over time. Further, in several cases, all of the information of interest was not readily available for a program or only certain years of data were available. It also is important to note that different programs have and provided data using different measurements. For example, expenditures can be monitored and measured in multiple ways – e.g., incurred claims versus payments out to providers – and these measurements capture different types of information. Administration may cover different types of expenses depending on the program. While in most cases, we obtained data for state fiscal years, in some cases, programs provided data for other time units (e.g., calendar year, county fiscal year). Data specifications and limitations are noted throughout the report. We also summarize data limitations and lessons learned in the final section of the report.

Organization of Report

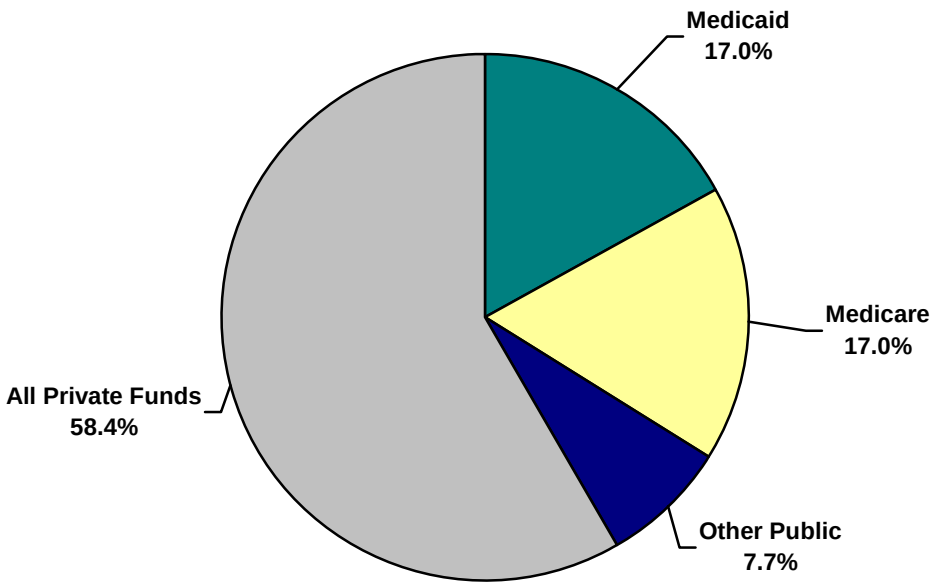
The balance of this report is organized into three sections. First, we present an overview of health expenditures in Idaho and situate Idaho's expenditures in a broader context using CMS and NASBO data. In the next section, we present program-specific information. We group the programs into five categories based on total health expenditures: Medicare; Medicaid/CHIP; public employee health plans (state, county, school district, city); safety net programs (state catastrophic health care program county indigent care, high risk pool, and community health care centers); and other public programs (correctional health care spending, public health services, tax expenditures). For each program, we provide a brief summary of the program and present available data on program financing, enrollment, medical and administrative expenditures, and detailed medical expenditures by service category and diagnosis when available. The final section of the report summarizes public health care expenditures across programs, identifies data limitations and lessons learned, and outlines recommendations for future monitoring of public health care expenditures in the state of Idaho.

OVERVIEW OF HEALTH CARE EXPENDITURES IN IDAHO

In 2004, total public and private health care expenditures in Idaho were $5.6 billion (CMS State Health Expenditure Accounts), representing 13.0% of the gross state product for 2004.[3]

This section of the report presents CMS National and State Health Expenditure Account information and state expenditure data from NASBO to provide an overview of sources of funding and key categories of health expenditures in Idaho.

Figure 1. Idaho's Total Personal Health Care Expenditures (PHCE) by Funding Source (2004)



Total Expenditures: $5.6 billion

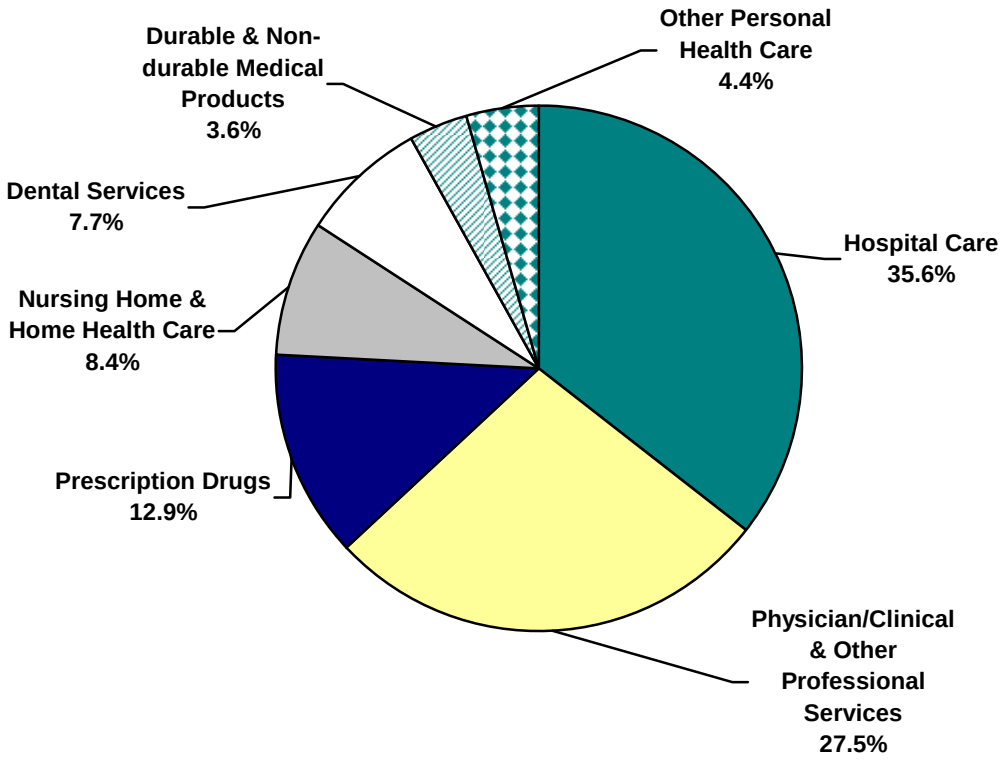
Source: Medicaid and Medicare shares are from the State Health Expenditure Accounts, 2004, Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group. Other Public funds are estimated for Idaho based on the national estimate for these funds from the CMS National Health Expenditure Accounts (NHEA), 2004. All Private Funds are estimated for Idaho and represent the residual share of funds.

Notes: Medicaid includes state & federal Medicaid dollars. Other Public includes state & local subsidies to hospitals & home health agencies; school health programs; Medicaid CHIP expansion; CHIP; maternal & child health; vocational rehab medical payments; temporary disability insurance medical payments; public health service & other federal hospitals, Indian Health Service; alcoholism/drug abuse/mental health programs. Percentages do not total 100% due to rounding.

As shown in Figure 1, private funds accounted for the majority (58.4%) of all health care spending in Idaho in 2004, totaling an estimate of $3.2 billion. The balance of health care spending in Idaho, 41.7% or approximately $2.3 billion, came from public funds. For 2004, Idaho's share of public health care spending is lower compared to that at the national level (41.7% vs. 44.6%).[4]

At $1.9 billion, Medicaid and Medicare combined (including federal and state funds) constituted a third of total spending and 78.2% of public spending on health care in Idaho in 2004. Other public funds (e.g., CHIP dollars, subsidies to hospital and home health care agencies, the Indian Health Service) make up an estimated 7.7% of the total health care spending and 17.7% of public spending in the state.

Figure 2. Idaho's Personal Health Care Expenditures (PHCE) by Service Type (2004)

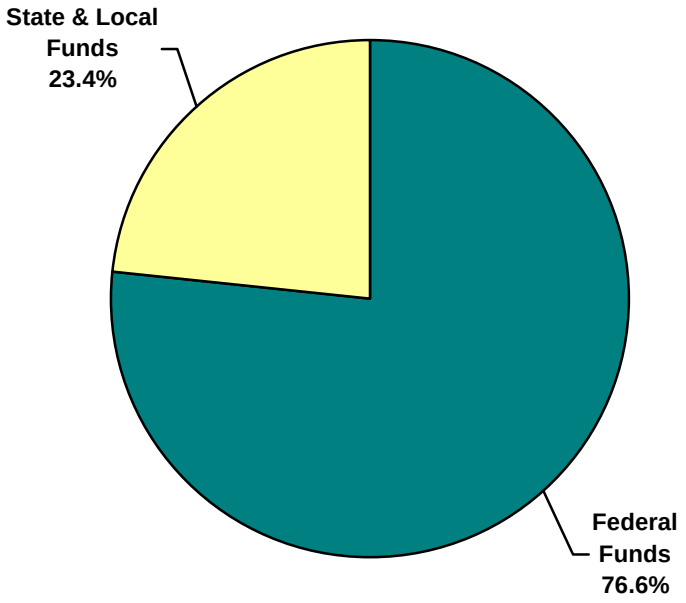


Total Expenditures: $5.6 billion

Source: Idaho Personal Health Care Expenditures (PHCE), All Payers, 1980-2004. CMS, Office of the Actuary, National Health Statistics Group.
Note: Percentages do not total 100% due to rounding.

Figure 2 shows the distribution of Idaho's public and private health care spending by type of service in 2004. Hospital care represented the largest component of spending with 35.6% ($2 billion) in expenditures, followed by physician/clinical and other professional services, which account for 27.5% ($1.5 billion), and prescription drugs (at 12.9% or $0.7 billion). Nursing home and home health care (8.4%), dental services (7.7%), other personal healthcare (4.4%), and durable and non-durable medical equipment (3.6%) made up the remaining shares of health care spending in the state. Idaho's health care spending mirrors national trends for the same time period.[5]

Figure 3. Idaho's Estimated Public Personal Health Care Expenditures (PHCE) by Funding Source (2004)



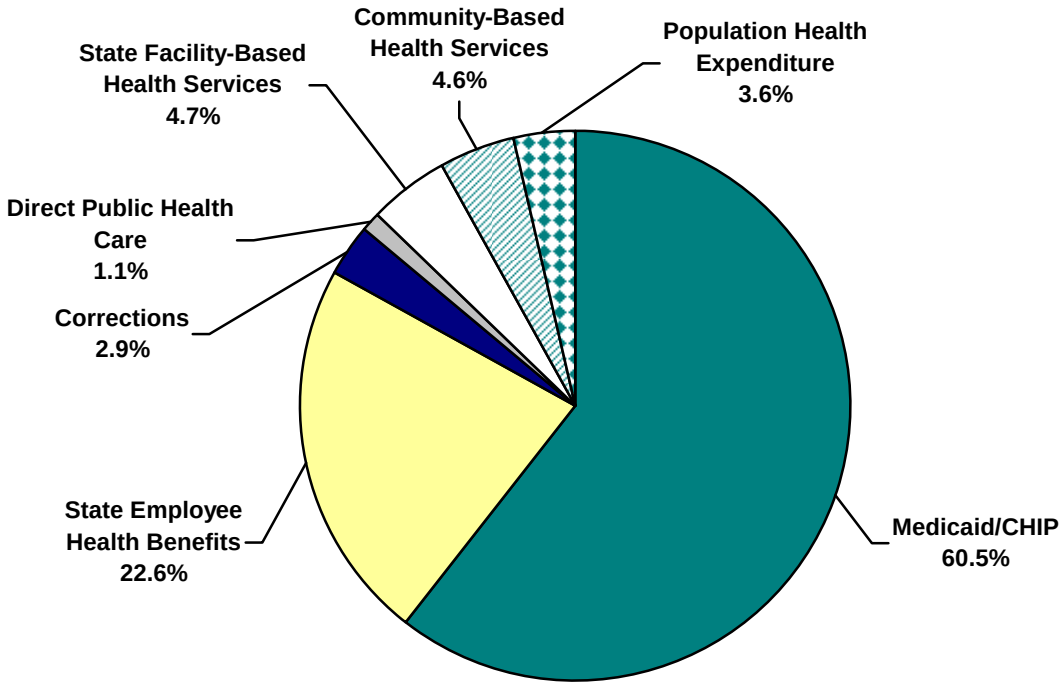
Estimated Total Public Funds: $2.3 billion

Source: Shares of federal and state & local funds were estimated for Idaho based on the national distribution of such funds from the CMS National Health Expenditures Account (NHEA), Table 10: PHCE, by Type of Expenditure and Source of Funds: CY 1998- 2005.

Notes: As relevant, shares include contributions to Medicare, Medicaid, CHIP programs, state and local subsidies to hospitals & home health agencies; school health programs; maternal & child health; vocational rehab medical payments; temporary disability insurance medical payments; public health service & other federal hospitals, Indian Health Service; alcoholism/drug abuse/mental health programs.

Idaho's public expenditures are estimated to total $2.3 billion in 2004. Figure 3 provides the estimated distribution of Idaho's public health care dollars by source of funds for 2004. Federal funds accounted for the largest share of public health care spending, representing 76.6% or $1.8 billion. State and local funds accounted for the balance of public health care expenditures, an estimated 23.4% or $549.1 million.

Figure 4. Idaho's Projected State Health Expenditures by Program Type (2004)



Source: Estimates for 2004 were produced using data from the 2002-2003 State Health Expenditure Report (National Association of State Budget Officers). Data include state dollars only. Estimates assume the same rate of change across all programs.

Notes: State Employee Health Benefits includes state employee-related expenditures on health premium; health premium-matching; flexible spending accounts; and Medicare payroll tax expenditure. Corrections includes adult and juvenile corrections health care expenditures. Population Health include expenditures on prevention of epidemics and the spread of disease; protection against environmental hazards; injury prevention; promotion of chronic disease control and encouragement of health behavior; disaster preparation; and health infrastructure. Facility-Based Health Services may include mental health/substance abuse hospitals, rehab facilities, and veterans' homes. Community-Based Services include alcohol/drug abuse treatment and mental health/developmental disabilities services. Direct Public Health may include services for AIDS treatment, emergency health services, etc.

While federal funds constitute the largest component of public health care spending (Figure 3), state funds contribute to and support vital health-related programs at the state level including Medicaid, CHIP, health benefits for state employees, and health care for the state's correction populations.

Figure 4 provides the estimated distribution of Idaho's state health spending by program type in 2004. Medicaid/CHIP accounted for the largest portion of state health spending (projected at 60.5% or $272 million) followed by state employee health benefits (22.6% or $102 million). These together accounted for 83.1% of all state health care spending. The balance of state spending in 2004 is on state facility-based health services and community-based health services (4.6% each), population health expenditure (3.6%), health care for the state's correction population (2.9%), and direct public health care spending (1.1%).

In SFY 2005, Idaho, compared to other states, ranked the 8th *lowest* in terms of per capita state health care expenditure – $3,359, compared to the average state per capita spending of $4,173 (data not shown).[6] A number of reasons may be a factor in Idaho's lower state spending on health care in the past. Examples include the scope of the state's health care policies and programs, the state's higher Federal Medical Assistance Percentage (FMAP) for Medicaid and CHIP (discussed later)[7], the state's eligibility levels for Medicaid and CHIP, and the role of county funding in the state's health care safety net.

Summary

- In 2004, a total of $5.6 billion in public and private funds was spent on health care in Idaho. Of these expenses, $2.3 billion, or 41.7%, are estimated to have been funded by public dollars.
- Federal funds constituted the majority (76.6%) of public health care spending with state and local spending accounting for 23.4% or $549.1 million.
- Medicaid/CHIP and state employee health benefits were the largest categories of health care spending, totaling approximately 83.1% of state health care expenditures.

PROGRAM-SPECIFIC INFORMATION

This section of the report provides more detailed information about specific programs of interest to the Idaho Legislature and OPE. Health care expenditures are organized into five groups:

1. Medicare,
2. Medicaid/CHIP,
3. Public employee health insurance (including state employee/retiree health benefits and local public employee/retiree health benefits),
4. The safety net (county medical indigent care program, the state Catastrophic Health Care Cost Program, Individual High Risk Reinsurance Pool, and community health care centers), and
5. Other public health care spending (including state and county jail corrections, public health service expenditures, and tax expenditures).

For each program, we provide a brief summary of the program, describe the data we compiled for the program, and present available data on program financing, enrollment, medical and administrative expenditures, and detailed medical expenditures by service category and diagnosis. More specific information about the data sources may be found under each table and figure as well.

MEDICARE

MEDICARE

Program Description

Medicare is a national health insurance program for people aged 65 years and older; individuals with disabilities; railroad retirees; and those with End-Stage Renal Disease (ESRD) and Lou Gehrig's disease. Medicare was passed into legislation in 1965 under Title XVIII of the Social Security Act and has since served as a key source of health insurance coverage for the elderly and individuals with disabilities.

Traditionally, Medicare consisted of two components: Hospital Insurance or "Part A" (covering inpatient care, home health, hospice care, and skilled nursing home facility care) and Supplementary Medical Insurance (SMI) or "Part B" (covering physician and outpatient care). Part A is financed through payroll taxes on employers and employees and beneficiary deductibles and coinsurance. Part B is financed via beneficiary premiums, deductibles, and coinsurance in addition to federal general fund tax revenue.

More recent changes to the Medicare program have introduced two additional components. "Part C" provides expanded options to beneficiaries to enroll in private managed care plans such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) or private Fee-for-Service (FFS) plans. Under the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, a new outpatient drug benefit ("Part D") was introduced for beneficiaries effective in 2006.

Data Sources

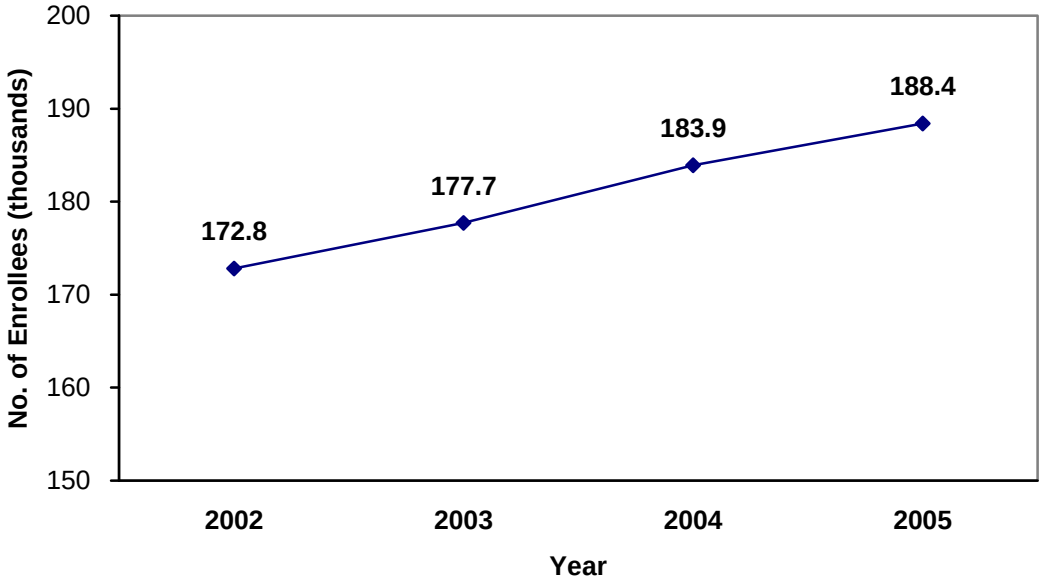
Idaho-specific Medicare enrollment and expenditure data were obtained from various CMS data sources—enrollment data for 2002-2004 were obtained from the Health Care Information Systems (HCIS), and data for 2005 is from the Medicare Beneficiary Data System. Medicare expenditure data for 2002-2004 were obtained from the Idaho Personal Health Care Expenditures (PHCE). Total Medicare expenditure as well as expenditures by service categories for 2005 were projected by SHADAC based on the available years. Projected expenditure estimates are based on the average change over the three year time period.

Findings

We present three sets of results: Medicare enrollment in Idaho, Medicare personal health care expenditures in the state, and the state's Medicare health expenditures by service type (e.g., hospital care).

Enrollment: Medicare

Figure 5. Idaho's Medicare Enrollment (2002-2005)



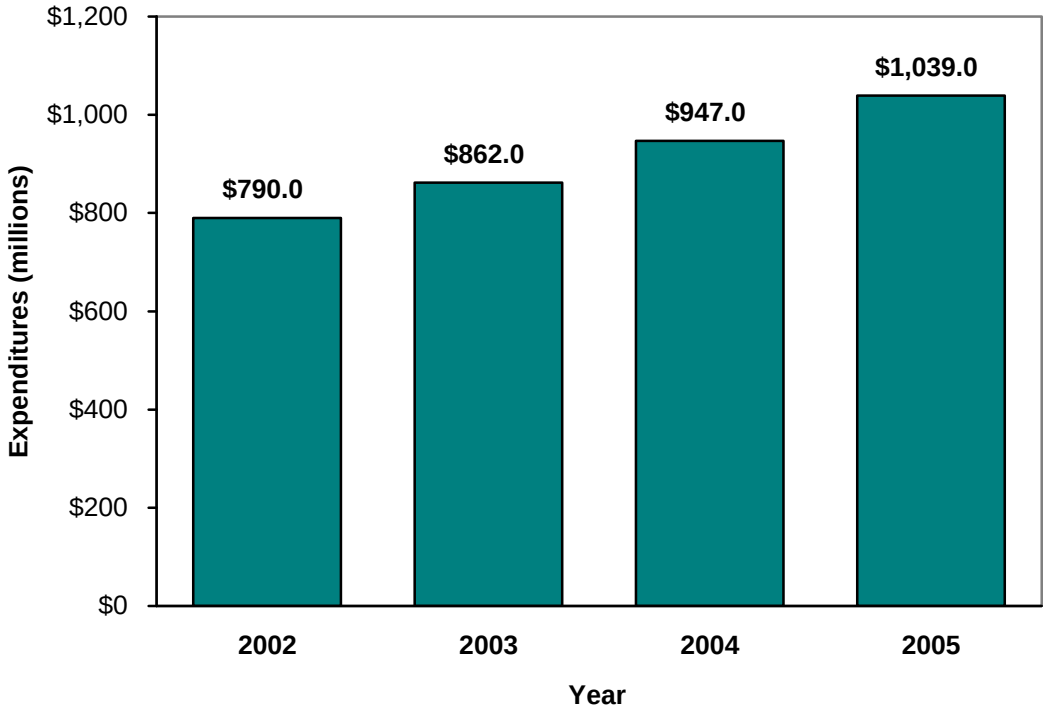
Source: Data for 2002-2004 are from CMS Health Care Information Systems (HCIS)[8]; data for 2005 are from CMS Medicare Beneficiary Data System.[9]

Notes: Data are as of July 1st and include those enrolled in Hospital Insurance (Part A) and/or Supplementary Medical Insurance (Part B).

Idaho's Medicare enrollment (in Part A and/or Part B) increased consistently between 2002 and 2005. The number of enrollees in Idaho grew from 172,787 to 188,414 enrollees, resulting in an overall increase of 9.0% during the four-year time frame. In 2005, Idaho's estimated enrollment represented less than 1.0% of the U.S.'s total Medicare enrollment, which is estimated to be 41,003,057. [10]

Public Health Care Expenditure: Medicare

Figure 6. Idaho's Medicare Personal Health Care Expenditures (PHCE) (2002-2005)



Source: Data for 2002-2004 are from Idaho Personal Health Care Expenditures (PHCE), All Payers, 1980-2004. CMS, Office of the Actuary, National Health Statistics Group. Expenditures for 2005 are projected using the same source.

In line with the state's increase in Medicare enrollment, Idaho's Medicare personal health care spending also regularly increased between 2002 and 2005, but at a more aggressive rate. Medicare spending in the state increased by 31.5% from $790 million in 2002 to a projected $1.0 billion in 2005. Medicare spending in Idaho represented less than 1.0% of total Medicare spending at a national level, which was $331.4 billion in 2005.[11]

Public Health Care Expenditures by Service Type: Medicare

Table 1. Idaho's Medicare Personal Health Care Expenditures (PHCE), by Service Type (2002-2005)

	2002		2003		2004		2005	
Service Type	$ (millions)	%	$ (millions)	%	$ (millions)	%	$ (millions)	%
Hospital Care	$456	57.9%	$494	57.3%	$532	56.2%	$575	55.3%
Physician & Other Professional Services	$211	26.8%	$230	26.7%	$260	27.5%	$289	27.8%
Nursing Home & Home Health Care	$84	10.7%	$94	10.9%	$106	11.2%	$119	11.5%
Durable & Non-Durable Medical Equipment	$31	3.9%	$37	4.3%	$39	4.1%	$44	4.2%
Prescription Drugs	$6	0.8%	$7	0.8%	$10	1.1%	$13	1.2%
Total	$788	100.0%	$862	100.0%	$947	100.0%	$1,039	100.0%

Source: Data for 2002-2004 are from Idaho Personal Health Care Expenditures (PHCE), All Payers 1980-2004. CMS, Office of the Actuary, National Health Statistics Group. Expenditures for 2005 are projected using the same source.

Table 1 details Medicare health care expenditures in Idaho, by type of health service, for 2002-2005. Hospital care was the largest category of Medicare spending, accounting for 55.3% in 2005. This share dropped slightly over time from 57.9% in 2002, representing an overall decline of 4.5%. Expenditures on physicians and other professional services comprised the next largest Medicare expense category, representing just above 25% of all Medicare spending for all four years. Durable and non-durable medical equipment and prescription drugs made up smaller shares, a combined 5.4% of total Medicare health care spending in Idaho in 2005.

Medicare expenditures by service type differ from overall state health care spending (see Figure 2) in a few key ways: Hospital care represented a much larger share of Medicare expenses, and nursing home and home health care spending also were slightly higher under Medicare. Medicare does not cover any dental care and had much lower prescription drug expenditures, although this will likely change since the introduction of Medicare Part D in 2006.

Highlights - Medicare

- Idaho's Medicare enrollment and personal health care expenditures increased in recent years, totaling approximately 188,414 enrollees and $1.0 billion in expenditures in 2005.
- Hospital care makes up the largest Medicare spending category in Idaho, accounting for just over half of Medicare's total personal health care spending.
- Idaho's Medicare enrollment and expenditures represented less than 1% of the U.S. Medicare program.

MEDICAID/CHIP

MEDICAID/CHIP

Program Description

The Division of Medicaid in the Idaho Department of Health and Welfare (DHW) coordinates comprehensive health coverage for Medicaid and CHIP-eligible Idaho residents. Both programs are funded by state dollars and receive matching federal funds to serve the health care needs of the low-income and disabled populations in the state. The Medicaid program, Title XVIII of the Social Security Act, is the public health care safety-net for uninsured low-income children, parents, pregnant women, individuals with disabilities, and the elderly. The state's program covers a wide variety of benefits including: inpatient/outpatient hospital services; clinic, physician, other practitioner services; community and institution-based long-term care services; physical/speech/hearing therapy; prescription drugs; medical equipment and supplies; transportation services; preventive, screening, and diagnostic services; and targeted case management.[12] As of state FY 2006, the federal match (FMAP) rate for Idaho's Medicaid program was 70.09%, with the state responsible for 29.91% of program spending. Eligibility levels for Idaho's Medicaid program (expressed as income at a percent of Federal Poverty Level (FPL)) are summarized in Table 2.

Table 2: Idaho's Medicaid Program: Income Eligibility Levels

Eligibility Groups	**Eligibility Level** (% of FPL)
Children	
Aged 0-5 Years	133%
Aged 6-19 Years	100%
Parents	
Working	43%
Non-working	23%
Pregnant Women	133%

Source: The Henry J. Kaiser Family Foundation. Statehealthfacts.org,[13]
Notes: Eligibility levels are as of July 2006.

With the passage of the Balanced Budget Act of 1997 (Title XXI of the Social Security Act), the State Children's Health Insurance Program (SCHIP) was implemented to provide health insurance coverage to children in families with incomes too high for Medicaid eligibility but too low to be able to purchase private health insurance coverage. States had the option of implementing their SCHIP programs using one of three approaches—establishing a program separate from their Medicaid program; expanding their Medicaid program for children; or a combination of both a separate program and Medicaid expansion. In 1998, Idaho started with a Medicaid eligibility expansion program, CHIP-A, and later introduced a separate CHIP program, CHIP-B, via an amendment in 2004. As of state FY 2006, the federal match rate for Idaho's CHIP programs was 79.06%, with the state responsible for 20.94% of program spending. Current eligibility levels for CHIP-A for children under 19 years of age is 150% FPL, and for CHIP-B, up to 185% FPL.

Effective FY2007, Idaho is undertaking efforts to modernize and reorganize its Medicaid and CHIP programs to meet specific health care needs of its residents. These efforts have resulted in

the following three Medicaid plans that target and manage the health needs of its enrollees. The plans include:

- The Medicaid Basic Plan, targeted at low-income children and adults who have eligible dependent children. This plan offers comprehensive health, prevention, and wellness benefits for children and adults without special health needs and conditions. This plan will include the majority of current Medicaid enrollees.
- The Medicaid Enhanced Plan, targeted at beneficiaries with disabilities and special health needs and conditions. The plan offers all the benefits of the Medicaid Basic Plan in addition to benefits that cater to the needs of the eligible beneficiaries.
- The Medicare-Medicaid Coordinated Plan, targeted at dual-eligibles who are low income and enrolled in both Medicare and Medicaid. Under this plan, enrollees receive all medical services offered under Medicaid that may not be covered by Medicare (e.g., dental care or community-based long term care services).

Effective July 2006, new Medicaid enrollees were assigned to either the Basic or the Enhanced plan depending on their health care needs. Those enrolled in Medicaid and CHIP-A prior to July 2006 will be transitioned into one of the two plans upon eligibility renewal. These transitions have been made for CHIP-B enrollees.

Apart from its CHIP programs, Idaho also has initiated additional programs through CMS Medicaid/CHIP waivers to improve access to affordable health care options for children and low-income working residents. In 2004, the state introduced its Idaho Access Card, a premium assistance alternative for CHIP enrollees. One year later, in 2005, the state implemented the Access to Health Insurance Program for low-income working residents. Through this program, eligible employees (including pregnant women, parents of Medicaid/CHIP enrollees and childless adults with incomes ≤ 185% FPL) can take advantage of employer-sponsored insurance through public contributions to small-employer health insurance premiums.

Data Sources

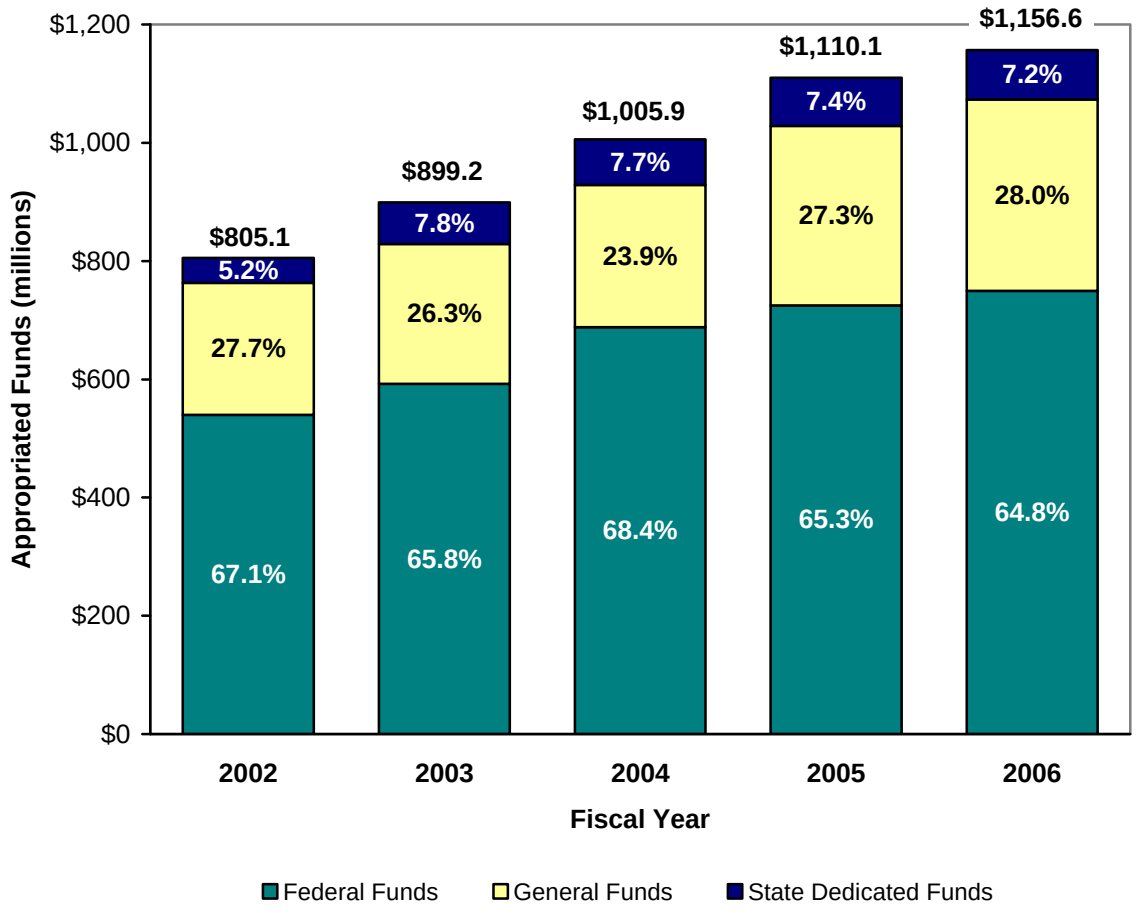
For this report, DHW provided summary appropriation and expenditure data for its Medicaid and CHIP programs for FYs 2002-2006. Data include information on sources of program funding, enrollment, eligibility groups, medical versus administrative expenses, and service types.

Findings: Medicaid/CHIP Combined

We first present details on the sources of funding (i.e., appropriations) for Medicaid and CHIP combined followed by more detailed information for each program on enrollment and medical expenditures by eligibility group and service type.

Sources of Revenue: Medicaid/CHIP

Figure 7. Idaho's Medicaid/CHIP Programs: Appropriations by Funding Source (FY 2002-2006)



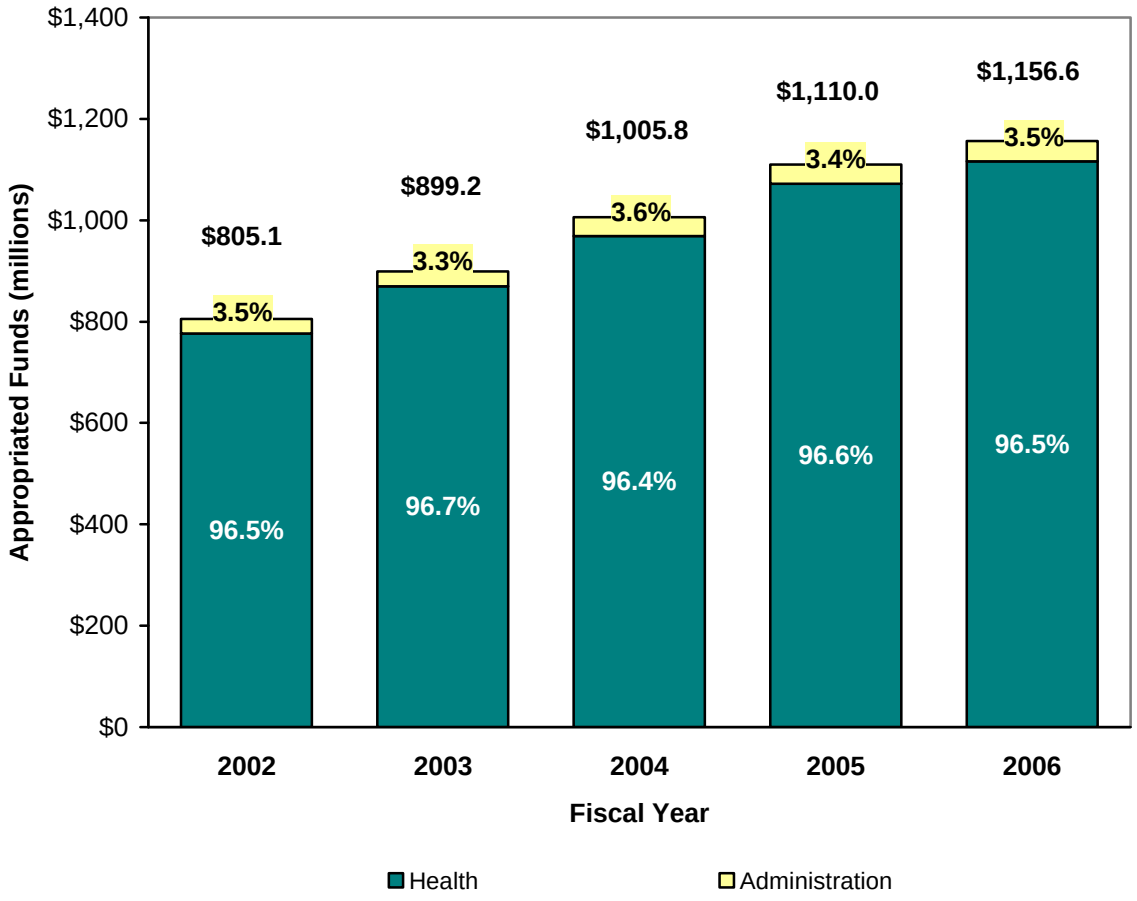
Source: Data provided by the Idaho Department of Health and Welfare, Division of Management Services.
Notes: State Dedicated Funds include Liquor Control Fund, Millennium Funds, Premium Tax (CHIP-B), Receipts, and Economic Recovery Funds. Appropriations are for medical payments, personnel, operating expenses, and capital outlay.

Figure 7 presents final government appropriations for Medicaid and CHIP combined for FYs 2002 through 2006 by source of funding. Total appropriations for these two programs have grown from $805.1 million in FY 2002 to over $1 billion in the last few years, resulting in an overall increase of 43.7%. (Separate data from the Kaiser Family Foundation suggests that growth in Idaho's Medicaid spending at least on benefit payments and disproportionate share hospital payments has been slightly greater than the average state.[14] Overall, states witnessed an average annual increase in such Medicaid spending of about 9.4% between 2001 and 2004 and 2.8% between 2004 and 2006. For Idaho specifically, these average increases were 10.8% and 4.4%, respectively. These data, however, do not take into account administrative and other expenses.)

Given Idaho's relatively high federal match rates for Medicaid and CHIP (compared to other states), the majority of Medicaid/CHIP appropriations (64.8% in 2006) are funded by federal

dollars. State general funds have supported as low as 23.9% (FY 2004) and as high as 28.0% (FY 2006) of the total appropriations for these programs. State dedicated funds nearly doubled during the five year time span, contributing $83.1 million or 7.2% of the appropriations for Medicaid and CHIP in FY 2006.

Figure 8. Idaho's Medicaid/CHIP Programs: Appropriations by Expenditure Category (FY 2002-2006)



Source: Data provided by the Idaho Department of Health and Welfare, Division of Management Services.
Notes: Administration includes personnel, capital outlay, and operating expenditures.

Figure 8 shows the allocation of total Medicaid and CHIP appropriations for health services and administrative expenditures. Appropriations for both health and administration increased between FY 2002 and 2006 (each by approximately 40%). Relative to total program funding, appropriations earmarked for administrative expenses stayed fairly constant at approximately 3.5%.

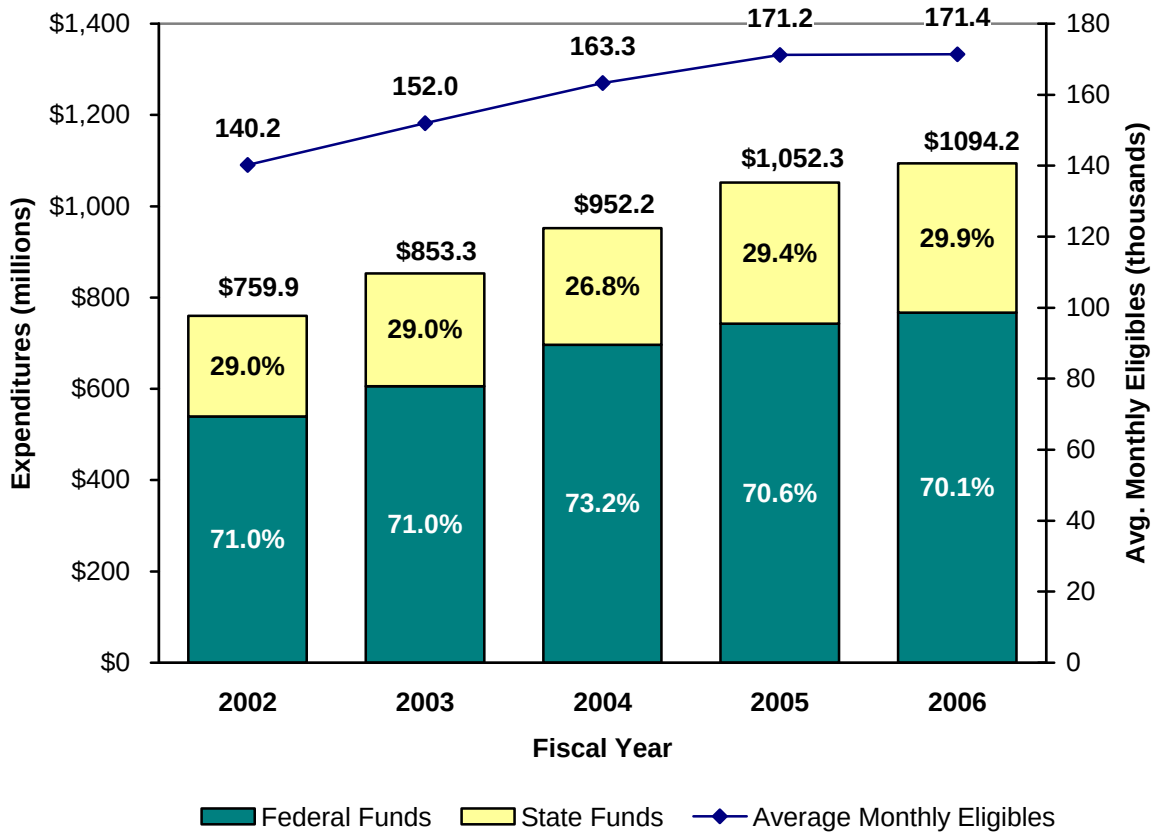
Highlights

- Total federal and state appropriations for Idaho's Medicaid and CHIP combined increased between FYs 2002 and 2006 by 43.7%, to over $1.0 billion in the last few years.
- State dedicated funds nearly doubled during the five year time span, contributing $83.1 million or 7.2% of the appropriations for the two programs in FY 2006.
- Appropriations for both health and administrative expenses increased between FY 2002 and 2006, each by approximately 40%.
- Appropriations for administrative spending fluctuated little during the five years, representing approximately 3.5% of total funding.

Findings: Medicaid

Enrollment and Health Expenditures: Medicaid

Figure 9. Idaho's Medicaid Program: Health Expenditures by Funding Source and Average Monthly Enrollment (FY 2002-2006)



Source: Data provided by the Idaho Department of Health and Welfare, Division of Medicaid.
Notes: Data are based on all Medicaid eligibility groups and include dual eligibles. Federal/state distribution was derived by applying the average federal FY match rate to total health expenditures for each state FY.

Enrollment in Idaho's Medicaid program and medical spending by the program increased between FYs 2002 and 2006 (see Figure 9). Data provided by DHW show that enrollment grew from 140,170 to 171,426 (or 22.2%) during the five-year period. In FY 2006, medical expenditures totaled $1.1 billion, up 44.0% from $759.9 million in FY 2002. In FY 2006, the state's share of Medicaid expenditures are estimated to be $327.3 million. State funds represented about 29.0% of the total medical expenditures paid by Idaho's Medicaid program in all years but FY 2004.

Table 3. Idaho's Medicaid Program: Health Expenditures and Average Monthly Enrollment, by Eligibility Group (FY 2002-2006)

Eligibility Group	2002	2003	2004	2005	2006
Low-Income Children					
Avg. Monthly Eligibles	85,783	94,461	101,966	106,532	104,958
Total Expenditures (millions)	$127.3	$155.5	$191.7	$221.5	$233.3
State	$37.0	$45.2	$51.4	$65.2	$69.8
Federal	$90.3	$110.4	$140.3	$156.3	$163.5
Working- Age Adults					
Avg. Monthly Eligibles	16,075	17,224	18,753	19,654	19,231
Total Expenditures (millions)	$82.9	$86.0	$105.8	$113.3	$120.7
State	$24.1	$25.0	$28.4	$33.3	$36.1
Federal	$58.8	$61.0	$77.4	$80.0	$84.6
Elderly					
Avg. Monthly Eligibles	16,233	16,949	17,819	18,780	19,768
Total Expenditures (millions)	$188.6	$202.5	$192.5	$209.0	$201.9
State	$54.8	$58.8	$51.6	$61.5	$60.4
Federal	$133.8	$143.7	$140.8	$147.5	$141.5
Individuals with Disabilities					
Avg. Monthly Eligibles	22,079	23,413	24,801	26,187	27,468
Total Expenditures (millions)	$361.2	$409.2	$462.2	$508.5	$538.3
State	$104.9	$118.8	$124.0	$149.6	$161.0
Federal	$256.3	$290.4	$338.2	$358.9	$377.3
Total					
Avg. Monthly Eligibles	140,170	152,047	163,339	171,153	171,426
Total Expenditures (millions)	$759.9	$853.3	$952.2	$1,052.3	$1,094.2
State	$220.7	$247.7	$255.5	$309.6	$327.3
Federal	$539.2	$605.6	$696.7	$742.7	$766.9

Source: Data provided by the Idaho Department of Health and Welfare, Division of Medicaid.

Notes: Data include dual eligibles. Individuals with disabilities include both children and adults. Federal/state distribution was derived by applying the average federal FY match rate to total health expenditures for each state FY.

Table 3 provides enrollment and health service expenditures for four key Medicaid eligibility groups—low-income children, working-age adults, elderly, and individuals (both adults and children) with disabilities—for FYs 2002-2006. Low-income children represent the largest category of enrollees accounting for 61.2% of total Medicaid enrollment in FY 2006. The next largest category is individuals with disabilities, who comprise 16.0% of total enrollees. While enrollment numbers for elderly and working-age adults have been consistent across the five fiscal years, medical expenditures for elderly Medicaid beneficiaries are consistently higher, sometimes exceeding the total expenditures for low-income children. Overall, however, individuals with disabilities have the largest share of total health expenditures, representing almost half 49.2% of total Medicaid expenditures in FY 2006.

In FY 2006, the state of Idaho contributed $69.8 million, $36.1 million, $60.4 million and $161.0 million in Medicaid spending for low-income children, working-age adults, elderly, and individuals with disabilities, respectively.

Health Expenditures by Service Type: Medicaid

Table 4: Idaho's Medicaid Program: Health Expenditures by Service Type (FY 2002-2006)

Service Type	2002		2003		2004		2005		2006	
	$ (millions)	%	$ (millions)	%	$ (millions)	%	$ (millions)	%	$ (millions)	%
Hospital Care	$147.3	19.4%	$178.5	20.9%	$194.4	20.4%	$210.9	20.0%	$217.0	19.8%
Nursing Home Care	$117.2	15.4%	$134.6	15.8%	$110.5	11.6%	$120.4	11.4%	$124.0	11.3%
Prescription Drugs	$114.0	15.0%	$128.5	15.1%	$145.8	15.3%	$166.6	15.8%	$134.8	12.3%
Physician and Clinical Services	$58.7	7.7%	$62.7	7.3%	$77.1	8.1%	$84.7	8.1%	$88.0	8.0%
Mental Health	$40.1	5.3%	$45.5	5.3%	$62.0	6.5%	$77.7	7.4%	$90.0	8.2%
Dental Services	$20.3	2.7%	$14.9	1.7%	$22.7	2.4%	$24.4	2.3%	$26.5	2.4%
Other Professional Services	$9.3	1.2%	$9.8	1.1%	$11.4	1.2%	$13.3	1.3%	$14.2	1.3%
Durable Medical Products	$8.7	1.1%	$9.1	1.1%	$10.2	1.1%	$11.9	1.1%	$14.2	1.3%
Home Health Care	$6.9	0.9%	$7.1	0.8%	$6.4	0.7%	$6.7	0.6%	$7.2	0.7%
Other	$237.3	31.2%	$262.7	30.8%	$311.6	32.7%	$335.7	31.9%	$378.4	34.6%
Total	$759.9	100.0%	$853.3	100.0%	$952.2	100.0%	$1,052.3	100.0%	$1,094.2	100.0%

Source: Data provided by the Idaho Department of Health & Welfare, Division of Medicaid.
Notes: Data are based on all Medicaid eligibility groups and include dual eligibles.

Information on Idaho's Medicaid health expenditures by service type for FYs 2002-2006 is presented in Table 4. In FY 2006, hospital care, nursing home care, and prescription drugs combined made up over two-fifths of total Medicaid spending (19.8%, 11.3%, and 12.3%, respectively). While the proportion of expenditures for hospital care and prescription drugs remained relatively stable over time (the only exception being a drop in prescription drug expenses in FY 2006 which is most likely attributable to the introduction of Medicare Part D), nursing home care's share of expenditures decreased over the five year period. On the other hand, Medicaid expenditures for mental health services increased by 54.7% between FYs 2002 and 2006, representing 8.2% of total Medicaid medical expenditures in FY 2006.

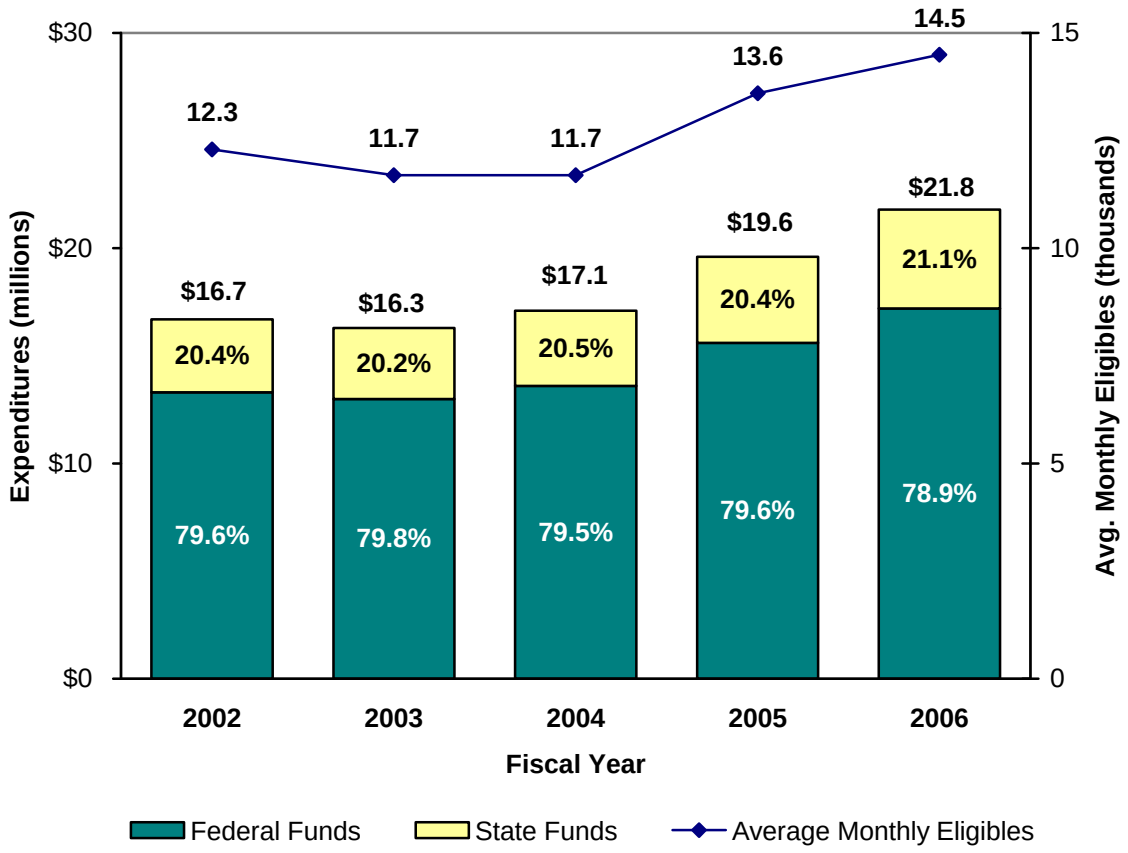
Highlights - Medicaid

- Idaho's Medicaid health expenditures grew by 44.0% between FYs 2002 and 2006 exceeding $1 billion in recent years. Idaho's Medicaid enrollment also increased during the same period but by a relatively smaller percentage (22%). In 2006, the state portion of Medicaid expenditures was $327.3 million (or 29.9%).
- Low-income children represented the largest category of enrollees (61.2%) followed by individuals with disabilities (16.0%).
- However, individuals with disabilities made up the largest proportion of total Medicaid health expenditures (49.2%). Relative to enrollment, the health expenditures for elderly beneficiaries were high as well, exceeding the expenditures for low-income children in some years.
- Hospital care (19.8%), nursing home care (11.3%), and prescription drugs (12.3%) made up noteworthy proportions of total Medicaid health spending in FY 2006. The relative shares for nursing home care decreased between FYs 2002 and 2006. Expenditures for mental health, on the other hand, increased by 54.7% to 8.2% of total health spending in FY 2006.

Findings: CHIP

CHIP Enrollment and Health Expenditures: CHIP

Figure 10. Idaho's CHIP Programs: Health Expenditures by Funding Source and Average Monthly Enrollment (FY 2002-2006)



Source: Data provided by the Idaho Department of Health and Welfare, Division of Medicaid.
Notes: CHIP-A expenditures and enrollment were available for all years. CHIP-B and Access Card programs began in FY 2005. Access to Health Insurance program began in FY 2006. Federal/state distribution was derived by applying the average federal FY match rate to total health expenditures for each state FY.

Figure 10 shows enrollment in Idaho's CHIP programs and total health spending by source of funds. As with the state's Medicaid program, enrollment in CHIP increased between FYs 2002 and 2006, from 12,329 to 14,492 children. However, unlike Medicaid, CHIP enrollment only shows increases since FY 2005, when CHIP-B and the Access Card programs were initiated. Health expenditures hovered around $16-17 million between FYs 2002 and 2004 and have grown with enrollment since FY 2005. Total CHIP health expenditures were $21.8 million in FY 2006. The state's share of CHIP spending (just over 20%) was $4.6 million in FY 2006; federal funds contributed the balance, totaling $17.2 million.

Table 5. Idaho's CHIP Programs: Health Expenditures and Average Monthly Enrollment (FY 2002-2006)

Eligibility Groups	2002	2003	2004	2005	2006
CHIP-A					
Avg. Monthly Eligibles	12,329	11,706	11,669	11,874	11,921
Total Expenditures (thousands)	$16,727.7	$16,281.0	$17,100.6	$18,044.3	$19,033.7
State	$3,400.5	$3,308.5	$3,521.6	$3,716.2	$3,985.6
Federal	$13,327.2	$12,972.5	$13,579.0	$14,328.0	$15,048.1
CHIP-B					
Avg. Monthly Eligibles	-	-	-	1,633	2,190
Total Expenditures (thousands)	-	-	-	$1,565.8	$2,546.8
State	-	-	-	$322.5	$533.3
Federal	-	-	-	$1,243.3	$2,013.5
Access Card					
Avg. Monthly Eligibles	-	-	-	78	87
Total Expenditures (thousands)	-	-	-	$13.0	$31.1
State	-	-	-	$2.7	$6.5
Federal	-	-	-	$10.3	$24.6
Access to Health Insurance					
Avg. Monthly Eligibles	-	-	-	-	294
Total Expenditures (thousands)	-	-	-	-	$205.9
State	-	-	-	-	$43.1
Federal	-	-	-	-	$162.8
Total					
Avg. Monthly Eligibles	12,329	11,706	11,669	13,585	14,492
Total Expenditures (thousands)	$16,727.7	$16,281.0	$17,100.6	$19,623.1	$21,817.4
State	$3,400.5	$3,308.5	$3,521.6	$4,041.4	$4,568.5
Federal	$13,327.2	$12,972.5	$13,579.0	$15,581.7	$17,248.9

Source: Data provided by the Idaho Department of Health and Welfare, Division of Medicaid.

Notes: CHIP-A expenditures and enrollment are available for all years. CHIP-B and Access Card programs began in FY 2005. Access to Health Insurance program began in FY 2006. Federal/state distribution was derived by applying the average federal FY match rate to total health expenditures for each state FY.

Table 5 provides information on CHIP enrollment and health expenditures for FYs 2002-2006 for Idaho's two CHIP programs (A and B) and for its Access Card and Access to Health Insurance waiver programs. CHIP-A enrollment has fluctuated little during the five year period, remaining slightly above or below 12,000 children. CHIP-A health expenditures, on the other hand, grew slightly (by 14%) during the same period, from $16.7 million in FY 2002 to $19.0 million in FY 2006. CHIP-B program enrollment increased by 34% to 2,190 children between the first year of the program (FY 2005) and FY 2006. CHIP-B health expenditures increased by 62.7% to $2.5 million in FY 2006.

Table 5 also provides enrollment and health expenditures for the Access Card (FY 2005 and FY 2006) and Access to Health Insurance program (FY 2006 only). During the first two years of the program, Access Card enrollment grew 11.5%, from 78 to 87 children. Expenditures for this program more than doubled during the same time frame, from $13,000 to $31,000. During its

first year, enrollment and medical expenditures for the Access to Health Insurance program were at 294 people and $205,000, respectively. Taking into consideration CHIP-A expenditure growth and the start up of the CHIP-B, Access Card and Access to Health Insurance programs, Idaho has witnessed an overall growth of 17.5% and 30.4% in its CHIP enrollment and spending, respectively.

Health Expenditures by Service Type: CHIP

Table 6. Idaho's CHIP Programs: Health Expenditures by Service Type (FY 2002-2006)

Service Type	2002		2003		2004		2005		2006	
	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%
Hospital Care	$4,264	25.5%	$4,625	28.4%	$3,835	22.4%	$4,234	21.6%	$4,277	19.6%
Physician/ Clinical Services	$2,844	17.0%	$2,647	16.3%	$2,796	16.4%	$3,353	17.1%	$3,630	16.6%
Dental Services	$2,630	15.7%	$2,432	14.9%	$2,494	14.6%	$2,483	12.7%	$2,693	12.3%
Prescription Drugs	$2,097	12.5%	$2,158	13.3%	$2,212	12.9%	$2,669	13.6%	$2,817	12.9%
Mental Health	$1,323	7.9%	$1,425	8.8%	$2,362	13.8%	$2,992	15.2%	$3,568	16.4%
Other Professional Services	$605	3.6%	$602	3.7%	$692	4.0%	$856	4.4%	$875	4.0%
Home Health Care	$14	0.1%	$49	0.3%	$14	0.1%	$30	0.2%	$36	0.2%
Nursing Home Care	$3	<0.1%	$9	0.1%	$0	0.0%	$0	0.0%	$0	0.0%
Durable Medical Products	$74	0.4%	$69	0.4%	$70	0.4%	$102	0.5%	$131	0.6%
Other	$2,873	17.2%	$2,266	13.9%	$2,625	15.4%	$2,905	14.8%	$3,790	17.4%
Total	$16,728	100.0%	$16,281	100.0%	$17,101	100.0%	$19,623	100.0%	$21,817	100.0%

Source: Data provided by the Idaho Department of Health and Welfare, Division of Medicaid.
Notes: CHIP-A expenditures and enrollment are available for all years. CHIP-B and Access Card programs began in FY 2005. Access to Health Insurance program began in FY 2006.

Table 6 provides detail on CHIP spending by service type for FYs 2002-2006. Hospital care (19.6%), physician/clinical services (16.6%), dental care (12.3%) and prescription drugs (12.9%) make up noteworthy proportions of health expenditures in FY 2006. The relative shares for hospital care and dental services decreased (by 23.1% and 21.7%, respectively) over the five year period. Mental health spending represented 16.4% of total CHIP health expenditures in FY 2006, double its share in FY 2002 (7.9%).

Highlights - CHIP

- In FY 2006, Idaho's CHIP enrollment was at 14,492, and health expenditures amounted to over $21.8 million. Federal funds supported approximately $17.2 million of these expenditures; the state incurred $4.6 million.
- Taking into consideration CHIP-A expenditure growth and the start up of the CHIP-B, Access Card and Access to Health Insurance programs, Idaho witnessed an overall growth of 17.5% and 30.4% in its CHIP enrollment and health expenditures, respectively, between FYs 2002 and 2006.
- Hospital care (19.6%), physician/clinical services (16.6%), mental health (16.4%), prescription drugs (12.9%), and dental care (12.3%) made up noteworthy proportions of total spending in FY 2006. The relative shares for hospital care and dental services decreased by over 20% each over the five year period. Expenditures for mental health more than doubled between FYs 2002 and 2006.

PUBLIC EMPLOYEE HEALTH BENEFITS:
STATE EMPLOYEES

STATE EMPLOYEE HEALTH BENEFITS

Program Description

The State of Idaho offers medical, behavioral, dental and vision insurance coverage to its employees and dependents. Medical benefits (not including vision or dental) also are available for state retirees and their dependents. Eligible employees include officers/employees of a state department, agency or institution (with the exception of University of Idaho) working at least 20 hours per week.[15] Individuals who are receiving monthly retirement benefits from the State Retirement System are eligible for state retiree group health benefits.[16] Eligible dependents include legal spouses and unmarried children up to age 23 who may be claimed as dependents for U.S. individual tax purposes.

For many years prior to FY 2005, Regence Blue Shield of Idaho held the contract for the employee/retiree medical plan. Business Psychology Associates (BPA) and Vision Services Plan (VSP) provided the behavioral health and vision benefits, respectively. Effective FY 2005, Blue Cross of Idaho is the carrier for the state employee/retiree medical plan. Mental health and substance abuse benefits continued as a separate contract to BPA until FY 2006; these benefits now are included under the Blue Cross of Idaho medical plans, although BPA continues to administers the Employee Assistance Plan (EAP) via a subcontract from Blue Cross of Idaho. Vision benefits also continue to be provided through a subcontract between Blue Cross of Idaho and VSP. A separate state contractor, Delta Dental, administers the state employee dental benefits.

Under the current state employee/retiree medical plan, two benefit options are available: Traditional and PPO Plans. Both offer hospital, physician, prescription drug, vision, mental health, substance abuse, and preventive benefits. The EAP (again managed by BPA) also is available under both plans. As of FY 2007, Traditional Plan monthly premiums for employees run from $29.50 (for employee only) to $98.00 (for employee, spouse and children). PPO Plan monthly premiums range from $23.00 (employee only) to $80.00 (for employee, spouse, and children). Annual individual deductibles are $350 (Traditional Plan) and $250 (PPO Plan, in network). Annual family deductibles are $1,050 (traditional plan) and $750 (PPO Plan, in network). As of FY 2007, there is no monthly vision premium for employee-only plans. The monthly employee premium for family vision coverage (employee, spouse, and children) is $6.00.

Delta Dental covers routine and preventive dental care, major services, and orthodontia. For FY 2007, the monthly employee premiums for dental insurance ranged from $4.50 (employee-only plan) to $45.25 (employee, spouse, and children). The annual deductible is $25 per person covered under the plan.

Data Sources

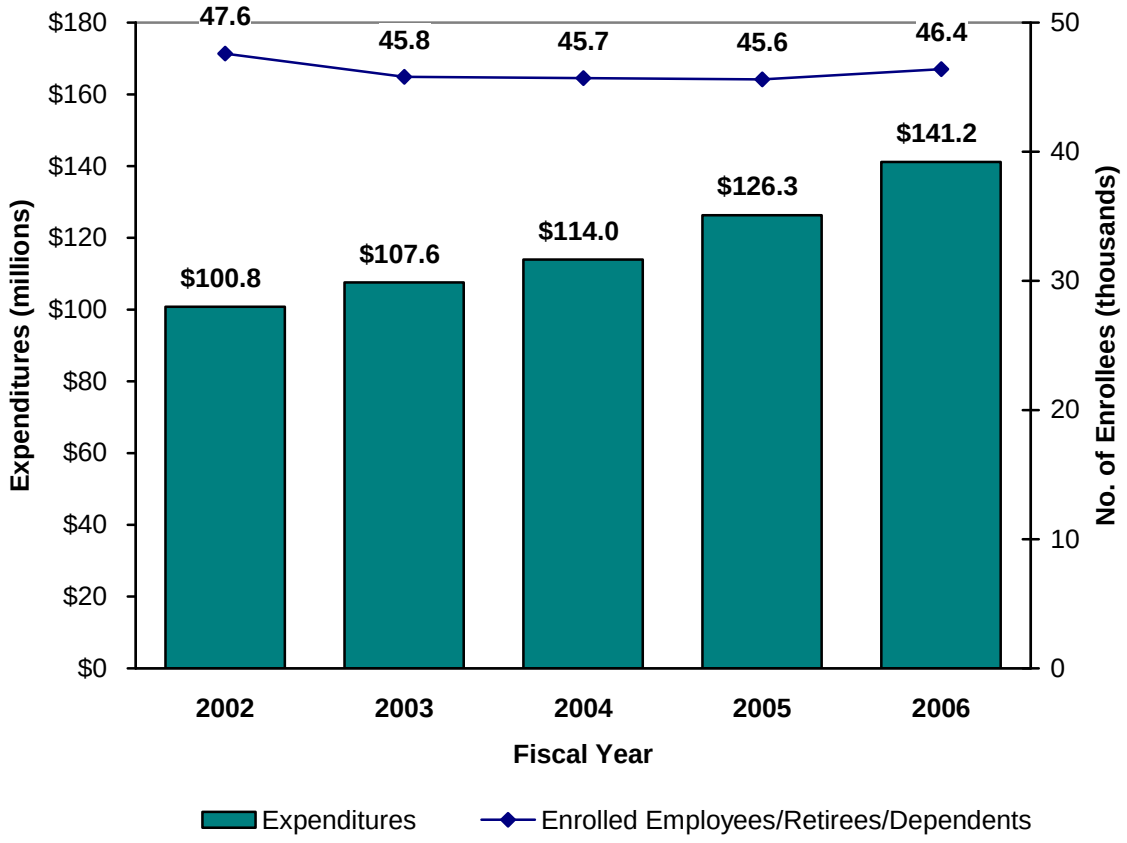
For this report, we obtained summary administrative data regarding the state's expenditures on state/retiree medical, mental health, vision, and dental benefits during FYs 2002-2006 from the Idaho Department of Administration. For all years, these data included plan enrollment, spending by expenditure category (e.g., medical claims, administrative expenses), and revenue

by key sources. More detailed data concerning medical spending by service category (e.g., hospital care) and for the top ten diagnosis categories (e.g., circulatory system) also were readily available for the Blue Cross medical contract for FYs 2005 and 2006. It is important to highlight that the medical expenditure data presented for these benefits are based on available data that represent incurred claims. These claims are for expenditures paid as well as charges incurred but not yet paid. It is possible that incurred claims overestimate the actual spending ultimately associated with these claims.

Findings: State Employee Medical Plan

Enrollment and Expenditures: State Employee Medical Plan

Figure 11. Idaho's State Employee Medical Plan: Total Expenditures and Enrollment (FY 2002-2006)



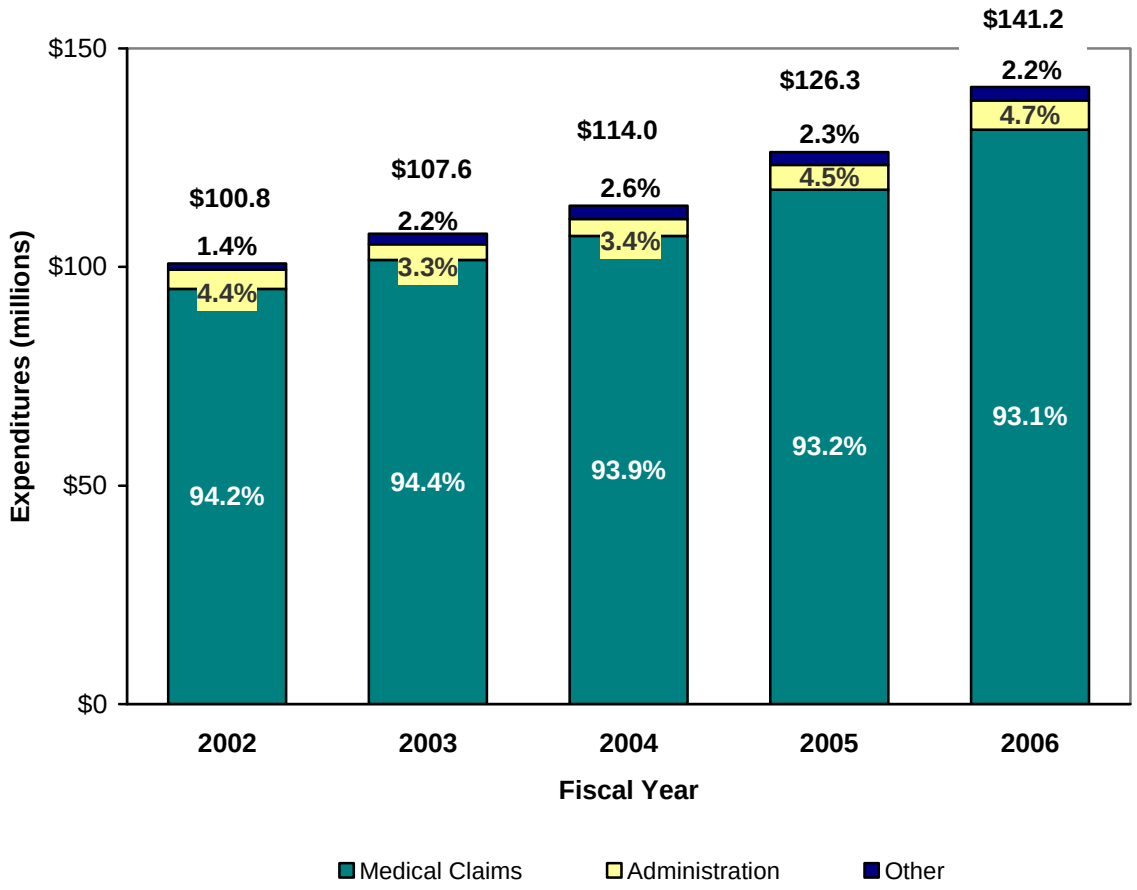
Source: Data provided by the Idaho Department of Administration.
Notes: Number of enrollees is based on average enrollment for each year. COBRA enrollees included. Expenditures include incurred medical claims, administration, premium tax, and vision and/or Integrated Behavior Health contracts.

Figure 11 provides enrollment (including employees, retirees, and dependents) and overall expenditures (including incurred medical claims and administrative expenses) for the state employee medical plan between FYs 2002 and 2006. Enrollment was at a five-year high in FY 2002 (47,620 enrollees) and then dropped to less than 46,000 in FY 2003, where it held steadily

until FY 2006. While the number of enrollees increased again in FY 2006, the program experienced a slight decrease of 2.5% in plan enrollment (from 47,620 to 46,387 enrollees) during the five year time span. Annual overall expenditures, on the other hand, increased by 40.1% during this time, from $100.8 million in FY 2002 to $141.2 million in FY 2006.

Medical vs. Administrative Expenditures: State Employee Medical Plan

Figure 12. Idaho's State Employee Medical Plan: Total Expenditures by Category (FY 2002-2006)



Source: Data provided by the Idaho Department of Administration.
Notes: Medical claims refer to claims incurred during year. Other includes premium tax and vision contract.

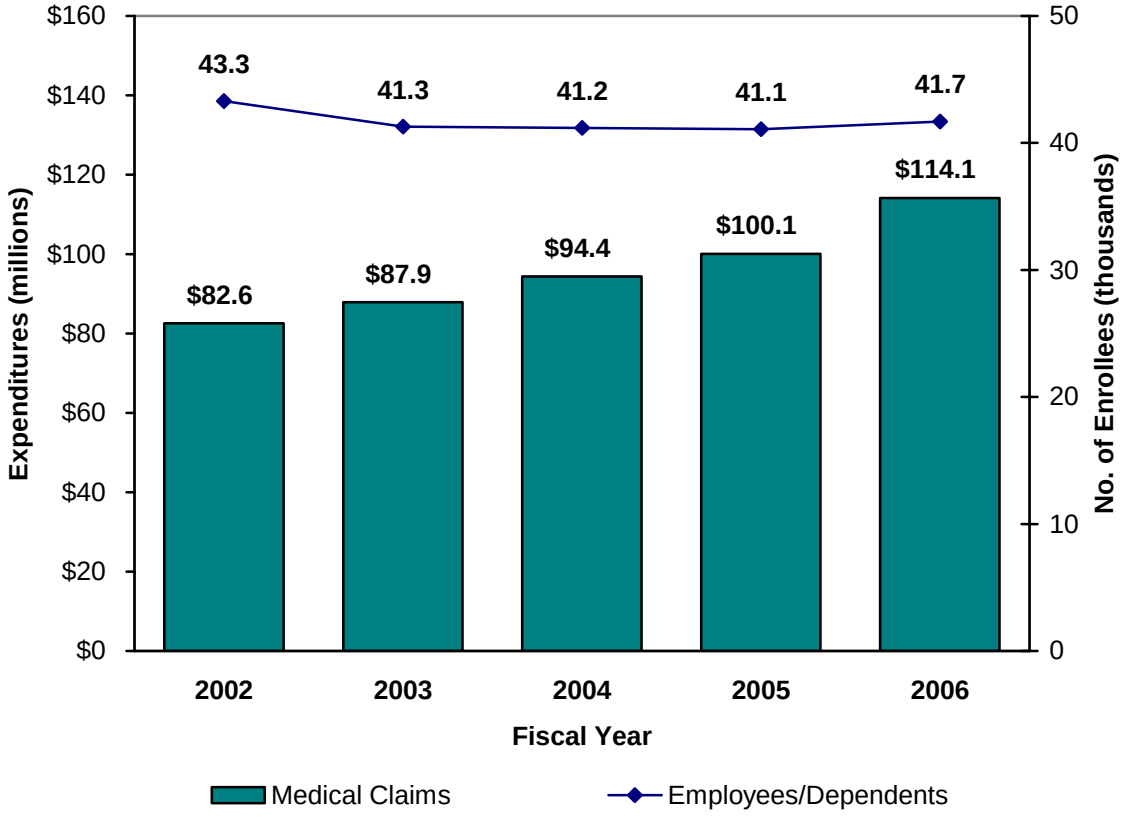
Figure 12 presents the composition of state spending for the state/retiree medical plan. During FYs 2002-2006, medical expenditures (incurred claims) increased by 38.3% (from $95.0 to $131.4 million) yet consistently represented 93-94% of total program spending during the five-year period. Administrative expenses increased by 50.9% between FYs 2002 and 2006 (from $4.4 to $6.7 million), maintaining less than 5.0% of total expenditures over time.

In Idaho, carriers are charged a premium tax of 1.4%. For the state employee medical plan contract, the tax is incorporated into the premium negotiated with the carrier. The carrier then

pays the tax, the funding from which is directed to the state general fund. The other category includes this 1.4% premium tax as well as expenditures for the vision care contract.

Medical Expenditures by Enrollment Group: State Employee Medical Plan

Figure 13. Idaho's State Employee Medical Plan: Incurred Medical Claims and Enrollment for Active Employees and Dependents (FY 2002-2006)

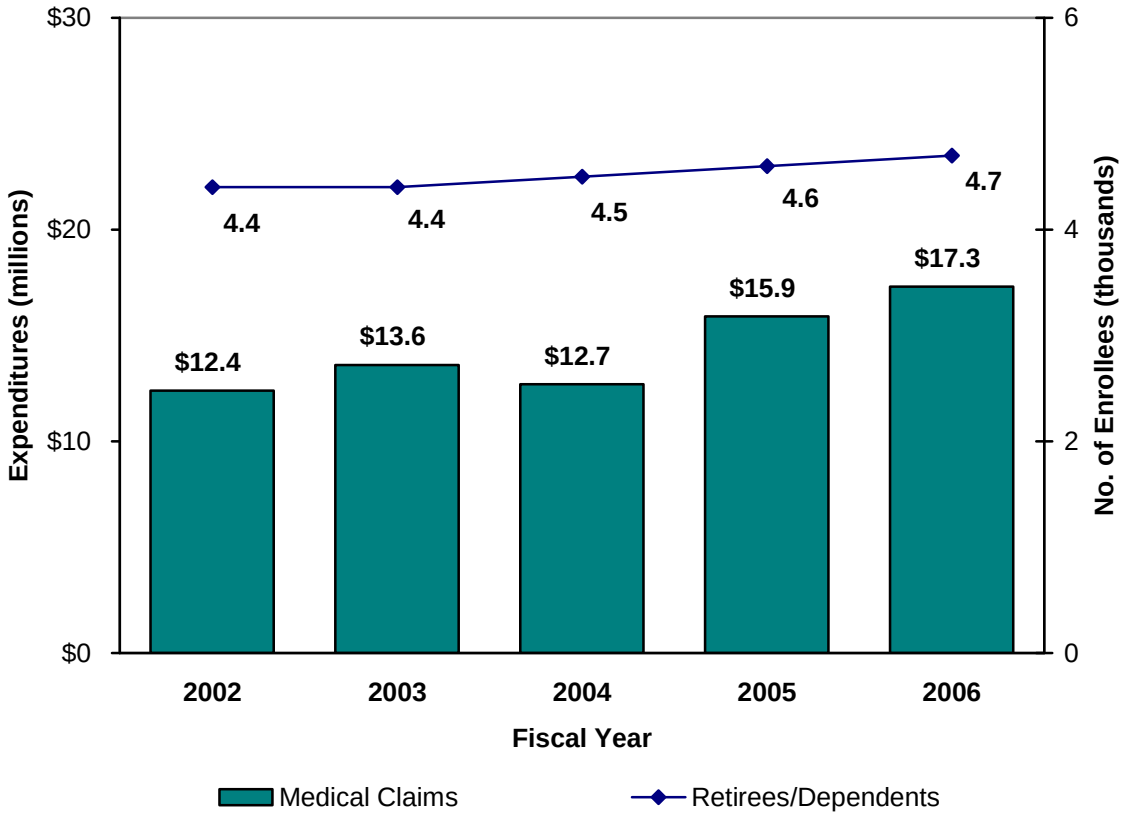


Source: Data provided by the Idaho Department of Administration.
Notes: Number of enrollees is based on average enrollment for each year. COBRA enrollees included. Expenditures include incurred medical claims, administration, premium tax, and vision and/or Integrated Behavior Health contracts.

Figure 13 provides enrollment and incurred medical claims for active employees and their dependents. We present similar information for enrolled state retirees and their dependents in a separate table below.

Since FY 2003, when the number of active employees and dependents last dropped modestly by 4.6%, the number of employees and dependents enrolled in the state employee medical plan has not changed dramatically, holding steadily at approximately 41,000, with a slight increase to 41,684 in FY 2006. During the same time period, however, incurred medical claims for active employees and their dependents increased significantly (by 38.1%) from $82.6 million in FY 2002 to $114.1 million in FY 2006.

Figure 14. Idaho's State Employee Medical Plan: Incurred Medical Claims and Enrollment for Retirees and Dependents (FY 2002-2006)



Source: Data provided by the Idaho Department of Administration.
Notes: Number of enrollees is based on average enrollment for each year. COBRA enrollees included. Expenditures include incurred medical claims, administration, premium tax, and vision and/or Integrated Behavior Health contracts.

Between FYs 2002 and 2006, the number of retirees and their dependents enrolled in the state/retiree medical plan grew slightly but consistently, increasing about 6.8% overall (see Figure 14). The proportion of total plan enrollees who were retirees (and their dependents) increased minimally, from 9.2% to 10.1% (data not shown in Figure). As with employees' incurred medical claims, claims for retirees and their dependents increased noticeably during the five year time-period – from $12.4 to $17.3 million (or by 39.5%). However, the proportion of overall medical claims incurred by retirees has not changed dramatically over time: Retiree claims represented 15.0% and 15.1% of total incurred medical claims in FY 2002 and 2006, respectively.

Medical Expenditures by Service Type: State Employee Medical Plan

Table 7: Idaho's State Employee Medical Plan: Incurred Medical Claims by Service Type (FY 2005-2006)

Service Type	2005		2006	
	$ (millions)	%	$ (millions)	%
Physician and Clinical Services	$32.7	27.7%	$36.7	27.9%
Prescription Drugs	$32.5	27.6%	$34.8	26.5%
Hospital Inpatient	$22.2	18.9%	$27.0	20.5%
Hospital Outpatient	$21.4	18.2%	$25.9	19.7%
Durable Medical Products	$3.3	2.8%	$3.4	2.6%
Mental Health	$1.7	1.5%	$0.3	0.3%
Home Health Care	$0.2	0.2%	$0.3	0.2%
Substance Abuse	--	--	<$0.1	<0.1%
Other	$3.7	3.2%	$2.9	2.2%
Total	$117.7	100.0%	$131.4	100.0%

Source: Data provided by the Idaho Department of Administration.
Notes: Data were not readily available for FYs 2002-2004. Substance abuse was not reported in 2005.

Table 7 provides information on the total medical claims incurred by the state employee medical plan by service categories. (These data were only readily available for the current Blue Cross of Idaho contract and therefore the two most recent FYs.) Hospital inpatient and outpatient care combined represent the largest share of medical claims (37.1% in 2005, 40.2% in FY 2006), followed by physician and clinical services (approximately 28% in both years) and prescription drugs (approximately 27% in both years). Mental health claims totaled $1.7 million in FY 2005 and only $338,400 in FY 2006.

Medical Expenditures by Diagnostic Category: State Employee Medical Plan

Table 8. Idaho's State Employee Medical Plan: Incurred Medical Claims by Top 10 Diagnostic Category (FY 2005-2006)

Diagnostic Category	2005		2006	
	$ (millions)	%	$ (millions)	%
Musculoskeletal System	$16.7	14.2%	$20.2	15.4%
Circulatory System	$9.8	8.3%	$11.1	8.5%
Digestive System	$6.0	5.1%	$10.9	8.3%
Myeloproliferative and Neoplasms	$5.1	4.3%	$7.5	5.7%
Nervous System	--	--	$6.0	4.6%
Factors Influencing Health Status	$4.2	3.5%	$5.1	3.9%
Skin, Subcutaneous Tissue & Breast	$4.1	3.5%	$4.8	3.7%
Respiratory System	$3.8	3.2%	$3.7	2.8%
Ear, Nose, and Throat	$3.6	3.1%	$3.5	2.7%
Female Reproduction System	$3.2	2.7%	--	--
Kidney and Urinary Tract	$3.1	2.6%	$3.6	2.7%
Total (among Top 10 diagnoses)	$59.5	50.5%	$76.5	58.3%

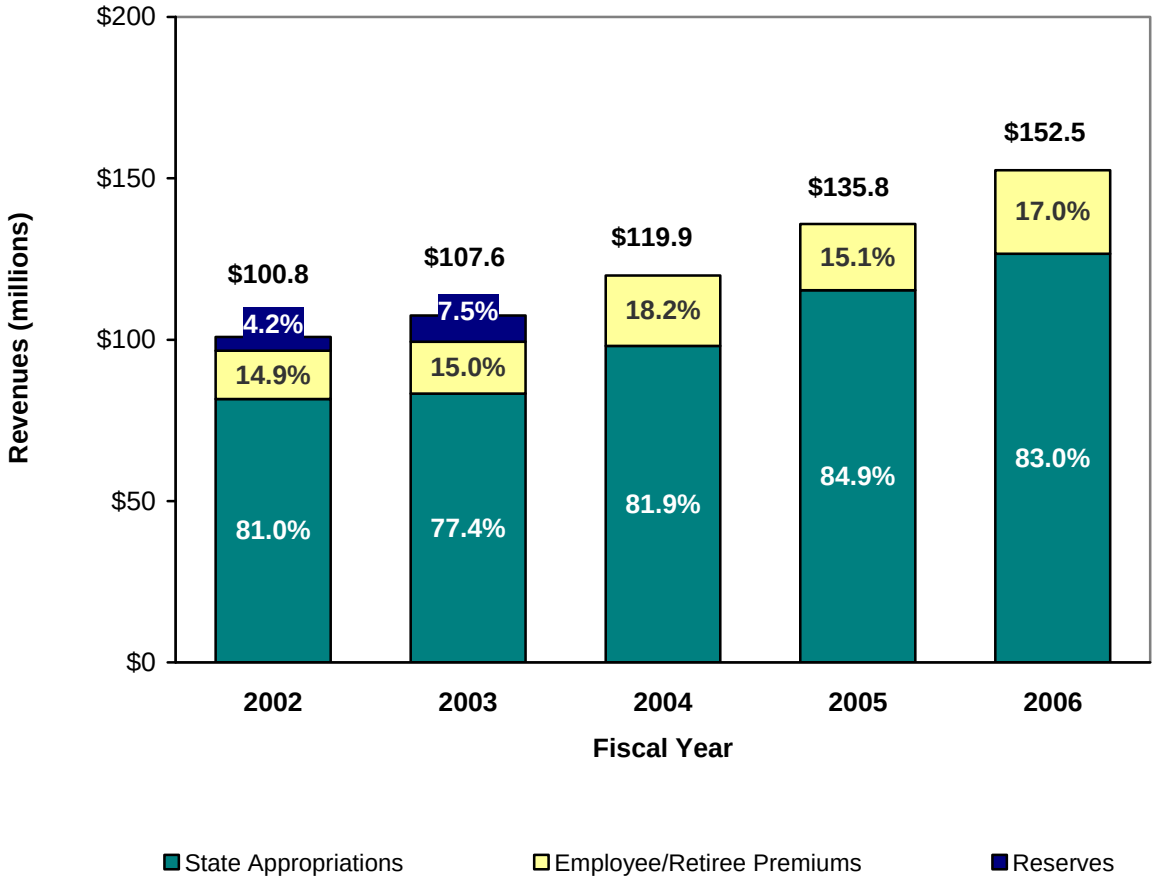
Source: Data provided by the Idaho Department of Administration.

Notes: Top 10 diagnostic categories are based on total claims incurred. Diagnostic categories are based on ICD-9 Major Diagnostic Categories (MDC). Percents shown represent the percent each category represents of total incurred claims.

Table 8 presents information on the medical claims incurred by the state employee medical plan for the top ten diagnoses in terms of health care spending. As with the service data presented on the previous page, these data were only available for the current Blue Cross of Idaho contract for FYs 2005 and 2006. The diagnosis categories presented are based on ICD-9 Major Diagnostic Category (MDC) classifications. Both years shared nine of the same top ten diagnosis groups: musculoskeletal system (diseases and disorders of the musculoskeletal system and connective tissues – e.g., spine); circulatory system (e.g., hypertensive disease); digestive system; myeloproliferative disorders and neoplasms (including both benign and malignant tissue growth); factors influencing health status ("diagnoses" or "problems" not otherwise categorized into the other disease or injury MDCs); skin, subcutaneous tissue, and breast; respiratory system; kidney and urinary tract; and ear, nose and throat. For both years, diseases and disorders of the of the musculoskeletal system represented the largest share of medical claims incurred by the state employee health plan (approximately 15%). All of the top ten diagnosis groups combined represented at least half of all the program's incurred medical claims during each year.

Sources of Revenue: State Employee Medical Plan

Figure 15. Idaho's State Employee Medical Plan: Revenue by Source (FY 2002-2006)



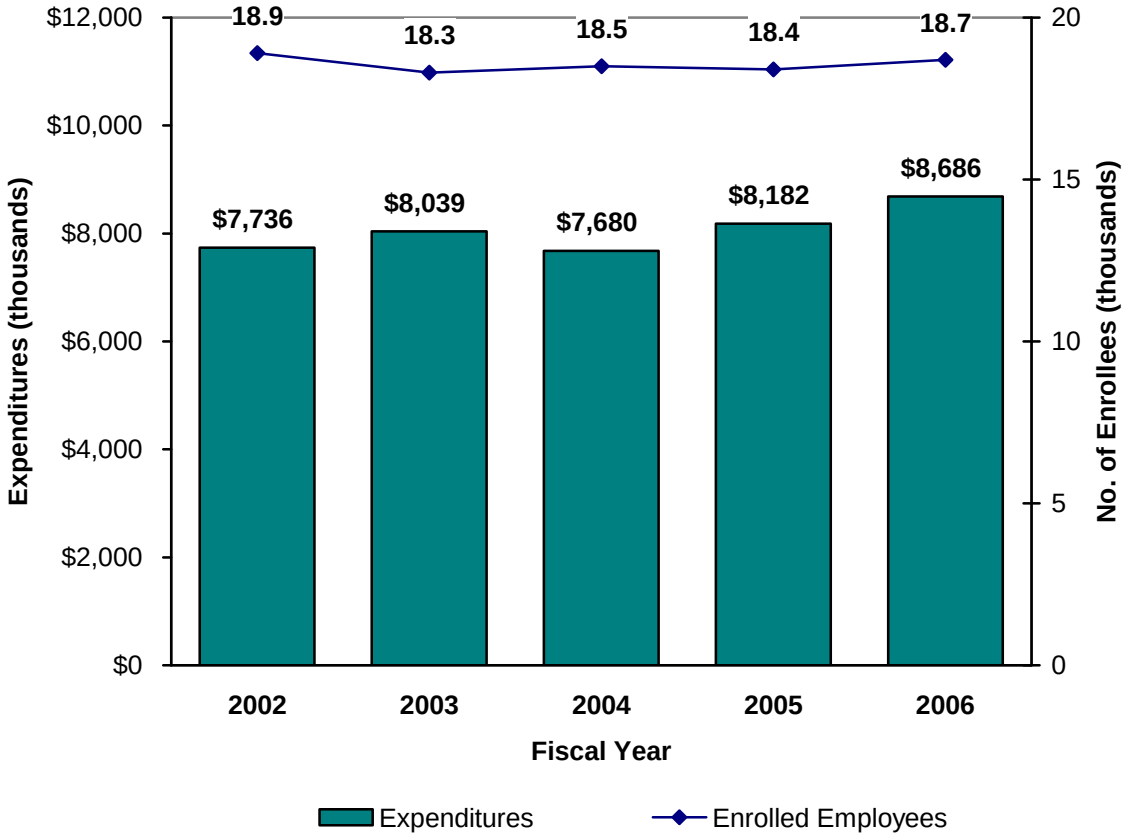
Source: Data provided by the Idaho Department of Administration.
Notes: Reserves were necessary to offset costs only in FY 2002 and FY 2003.

Three sources fund the state employee/retiree health benefits: state general fund appropriations, employee/retiree premiums, and reserve funds to offset losses as necessary. Figure 15 shows the composition of revenue for the state employee medical plan. Plan revenues totaled $152.5 million during FY 2006, up 51.2% from just over $100 million in FY 2002. State appropriations fund the majority of the medical plan. During the five-year period, these appropriations accounted for no less than 77.4% of the total revenue (FY 2002) and as much as 84.9% in FY 2005. Tapping into reserves was necessary to offset plan spending in FYs 2002 and 2003, when these reserves were required to cover as much as 7.5% of expenditures.

Findings: State Employee Dental Plan

Enrollment and Expenditures: State Employee Dental Plan

Figure 16. Idaho's State Employee Dental Plan: Total Expenditures and Enrollment (FY 2002-2006)

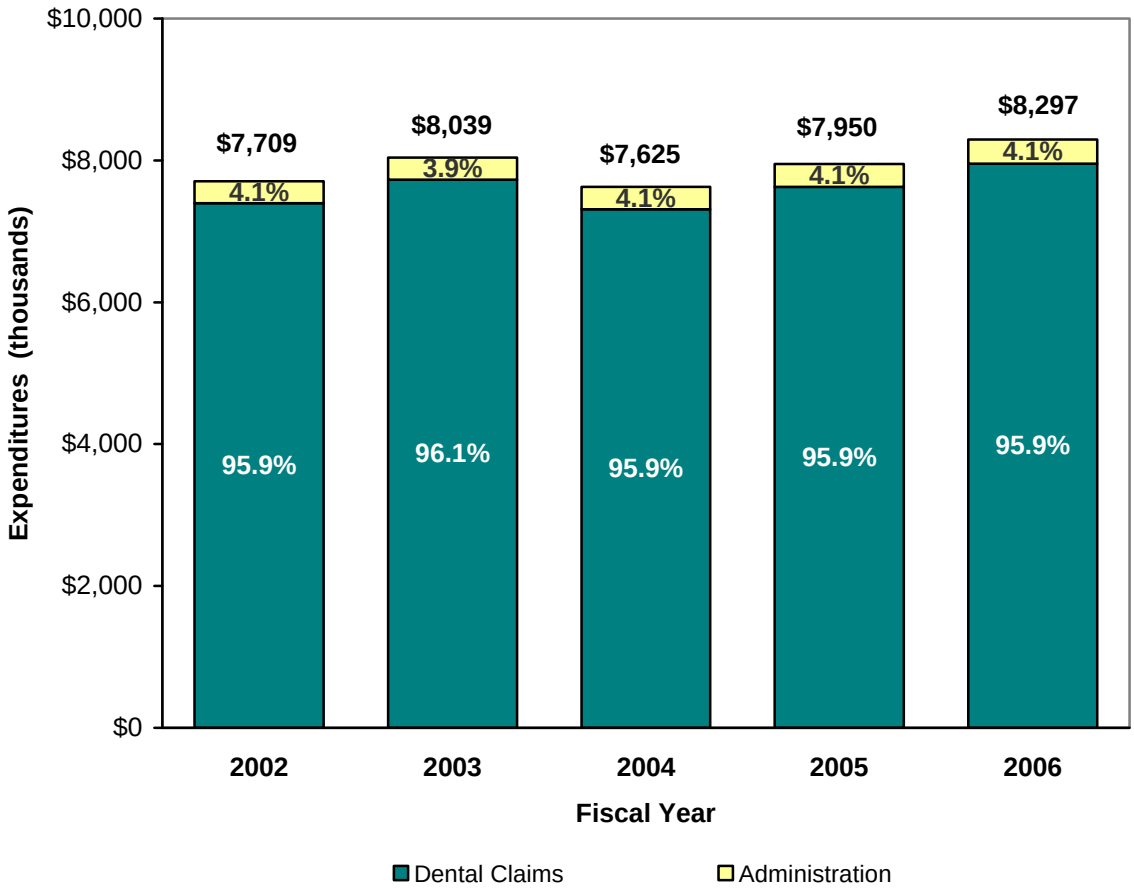


Source: Data provided by the Idaho Department of Administration.
Notes: Number of enrollees is based on actual enrollment on June 30 in each year. Expenditures include incurred dental claims and administration expenses.

Figure 16 provides an overview of enrollment and overall expenditures for the state employee dental plan between FYs 2002 and 2006. As with the state employee medical plan, enrollment in the dental plan was at a five-year high in FY 2002 (18,938 enrollees). Since then, it has fluctuated up and down slightly, with 18,714 employees and dependents enrollees in FY 2006 (for an overall relative decrease of 1% during the five years). Annual overall expenditures (including administrative expenses and incurred dental claims), on the other hand, increased by 12% between FYs 2002 and 2006, from $7.7 to $8.7 million.

Dental vs. Administrative Expenses: State Employee Dental Plan

Figure 17. Idaho's State Employee Dental Plan: Total Expenditures by Categories (FY 2002-2006)

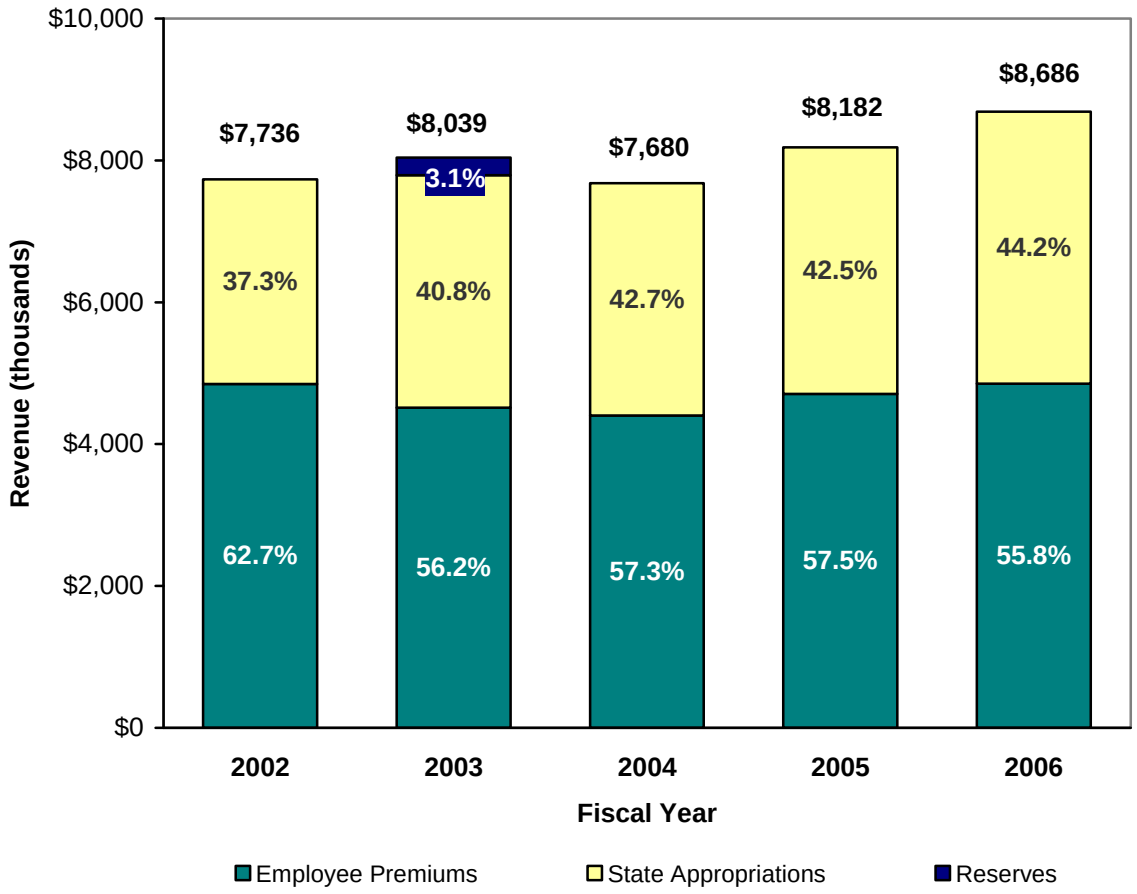


Source: Data provided by the Idaho Department of Administration.
Notes: Dental expenditures are incurred claims during year.

Figure 17 presents the composition of program expenditures for the state employee dental plan. During FYs 2002-2006, incurred dental claims increased slightly (from $7.4 to $8.0 million or 7.6%), yet consistently represented approximately 96% of total plan spending during the five-year period. Administrative expenses also increased between FYs 2002 and 2006 (by 9.2%, from $313,114 to $342,000), representing about 4% of total expenditures over time.

Sources of Revenue: State Employee Dental Plan

Figure 18. Idaho's State Employee Dental Plan: Revenue by Source (FY 2002-2006)



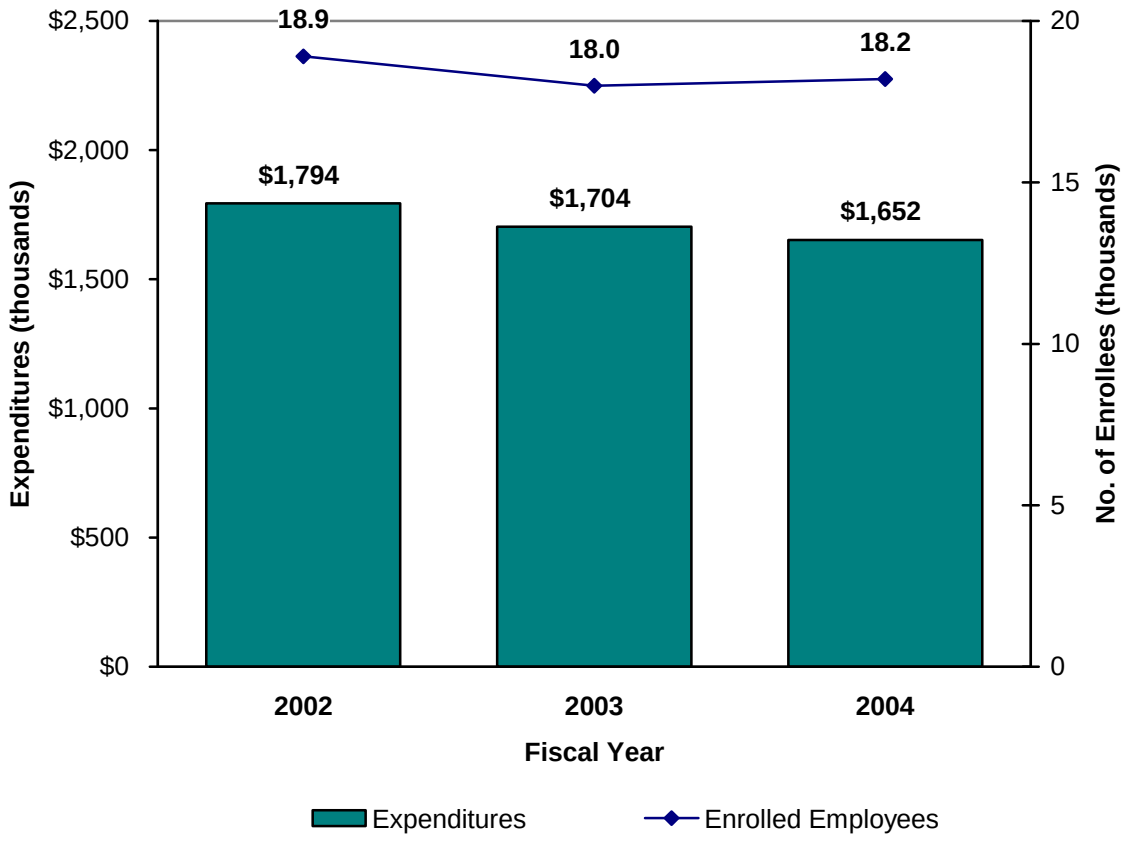
Source: Data provided by the Idaho Department of Administration.
Notes: Reserves were necessary to offset costs only in FY 2003.

As with the state employee medical plan, state general fund appropriations, employee/retiree premiums, and reserve funds support the state employee dental plan. Figure 18 details the composition of revenue for the dental plan. Revenues totaled $8.7 million during FY 2006, an increase of 12.2% from just over $7.7 million in FY 2002. In comparison to the state employee medical plan, employee premiums fund the majority of the dental benefits. During the five-year period, these premiums accounted for no less than 55.8% of the total revenue (FY 2006) and as much as 62.7% in FY 2002. Tapping into reserves was necessary to offset expenditures in FY 2002, when these reserves were required to cover $247,160 or 3.1% of expenditures.

Findings: State Employee Mental Health Benefits

Enrollment and Expenditures: State Employee Mental Health Benefits

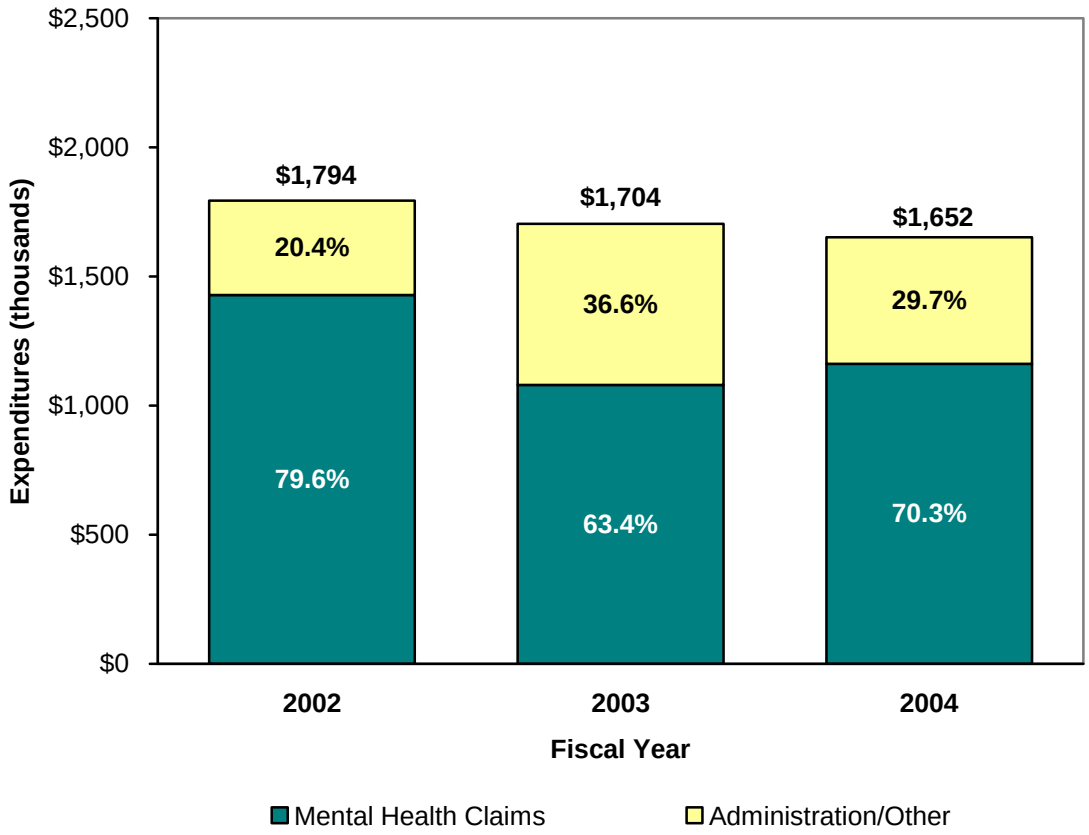
Figure 19. Idaho's State Employee Mental Health Benefits: Total Expenditures and Enrollment (FY 2002-2004)



Source: Data provided by the Idaho Department of Administration.
Notes: State employee mental health benefits were integrated into Blue Cross contract in FY2005. Number of enrollees is based on actual enrollment as of June 30 in each year. Total expenditures include medical claims and administration expenses.

Finally, Figure 19 presents the enrollment and overall expenditures for state employee mental health benefits between FYs 2002- 2004. (Data are not shown for FYs 2005 and 2006 because mental health benefits were subsumed under the new Blue Cross of Idaho contract.) Again, similar to that of the state medical and dental plans, enrollment in the BPA benefits plan was highest in FY 2002 (18,889) and then went down by 3.6%. Unlike the state employee medical and dental benefits, however, annual overall expenditures for mental health also dropped between FYs 2002 and 2004, from $1.8 to $1.7 million, representing a 7.9% decrease overall.

Figure 20. Idaho's State Employee Mental Health Benefits: Total Expenditures by Category (FY 2002-2004)



Source: Data provided by the Idaho Department of Administration.
Notes: The state employee mental health program was integrated into the Blue Cross contract in FY2005. Mental health claims are incurred claims during year. Administration/other includes administration expenditures and additional non-claims-related expenditures otherwise not specified.

Figure 20 shows the composition of expenditures under the state employee mental benefits plan. Between FYs 2002 and 2004, expenditures on mental health claims decreased overall (by 18.6%, from $1.4 to $1.2 million). Claims' role in overall spending fluctuated each year, representing 63.4% (FY 2003) to 79.6% (FY 2002) of overall benefit expenditures. Administrative and other expenses combined also varied during the three-year period, ranging from $366,407 (or 20.4%) of total spending in FY 2002 to as high as $624,300 (or 36.6%) in FY 2003. Administration represented 12.5% of spending in FY 2002 and grew to 16.8% in FY 2004.

Sources of Revenue: State Employee Mental Health Benefits

Idaho's state mental health benefits are funded entirely by state general fund appropriations. Total appropriations amounted to $1.8 million in FY 2002 and $1.7 million in FYs 2003 and 2004.

Highlights – State Employee/Retiree Medical Benefits

- Medical plan expenditures for state employees have increased by 40.0% totaling $141.2 million in FY 2006. Dental expenditures have fluctuated but have been on the increase since FY 2004 whereas expenditures on mental health benefits declined from FY 2002 through FY 2004.
- Enrollment of active employees/dependents in the state employee medical and dental plan as well as beneficiaries of mental health services was the highest in FY 2002 and has been on the decline since. Enrollment in the medical plan dropped modestly by 4.6% in FY 2002 through FY 2003; however, the number of enrollees held steady at approximately 41,000, with a slight increase to 41,684 in FY 2006.
- Between FYs 2002 and 2006, state medical and dental plan-related administration expenses stayed constant at less than 5.0% of program costs. Administrative and other non-claims-related expenses combined represented comprised approximately 30.0% of mental health benefit expenditures.
- Expenditures on physician and clinical services and prescription drugs accounted for the top two expense categories for the state medical plan in FYs 2005 and 2006, together adding up to more than half of total expenditures. During this time period, the top two costliest diagnostic categories were musculoskeletal system and circulatory system.

PUBLIC EMPLOYEE HEALTH BENEFITS:
LOCAL GOVERNMENT EMPLOYEES

LOCAL GOVERNMENT EMPLOYEE HEALTH BENEFITS

Program Description

As with state employees, eligible employees of local unit of governments also have access to health insurance through their employment in the public sector. This report focuses on local government employee health plans maintained by Blue Cross of Idaho and Regence Blue Shield of Idaho because these two carriers represent the majority of the health insurance market within the state of Idaho (Spencer et al. 2007, Blewett et al. 2007). Because cities, counties, and school districts make up the largest share of local government employee plans with these two carriers[17], we focus on the employee health plans for these units of government.

Data Sources

Data on county, city, and school district employee/retiree health plans were provided by Blue Cross of Idaho and Regence Blue Shield of Idaho and synthesized for the purposes of this report. Data are for FYs 2004-2006, are for both fully-insured and self-insured plans, and include, for each type of public entity, the number of member months, health care expenditures, as well as expenditures by key provider/service categories and for the shared top 5 general diagnostic categories.

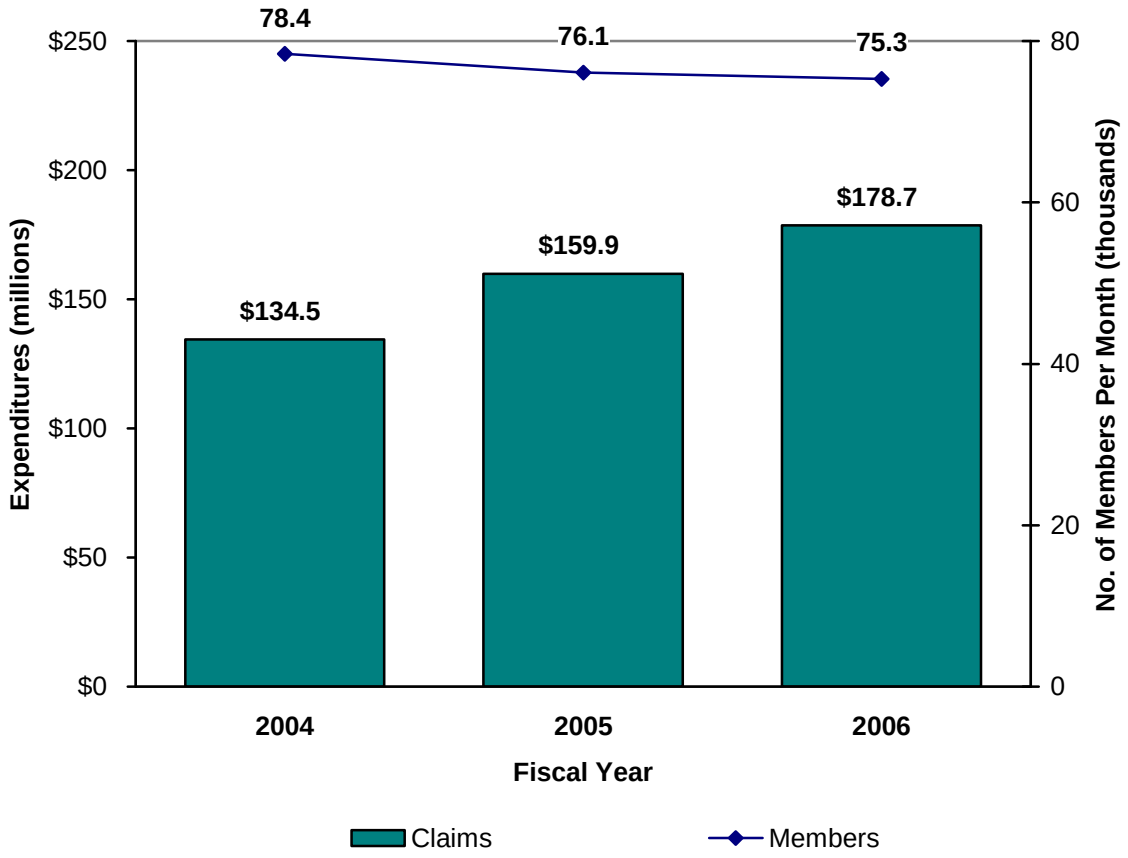
The expenditure information pertains to claims incurred by the carriers during each of the fiscal years and paid through May 2007. Because administration expenditures incurred specifically for these plans were not directly available, SHADAC estimated these expenditures based on total claims and total administration expenses for all lines of business as reported in the National Association of Insurance Commissioners (NAIC) annual financial statements for both carriers for CY 2006. In estimating administrative expenditures, we first calculated the share of county, city and school district employee claims of the total claims incurred by each carrier, and then applied that share (percentage) of the claims to the total administration expenditures for 2006. Estimated administrative expenditures for city, county, and school district health plans were then aggregated for both the carriers and are reported below for 2006. The estimates of administrative expenditures presented in this report do not account for all possible administrative expenses (e.g., broker services) associated with the plans of interest.

Because the data include all expenditures incurred and do not distinguish between employer and employee contributions, the data overestimate government expenditures for these local public employee health benefits. Additional plan information obtained, however, suggests that the majority of county, city, and school district employers pay for the majority of plan premiums.

Findings

Enrollment and Medical Expenditures: Local Public Employee Medical Plans

Figure 21. City, County, and School District Employee Health Plans in Idaho: Combined Total Medical Expenditures and Enrollment (FY 2004-2006)



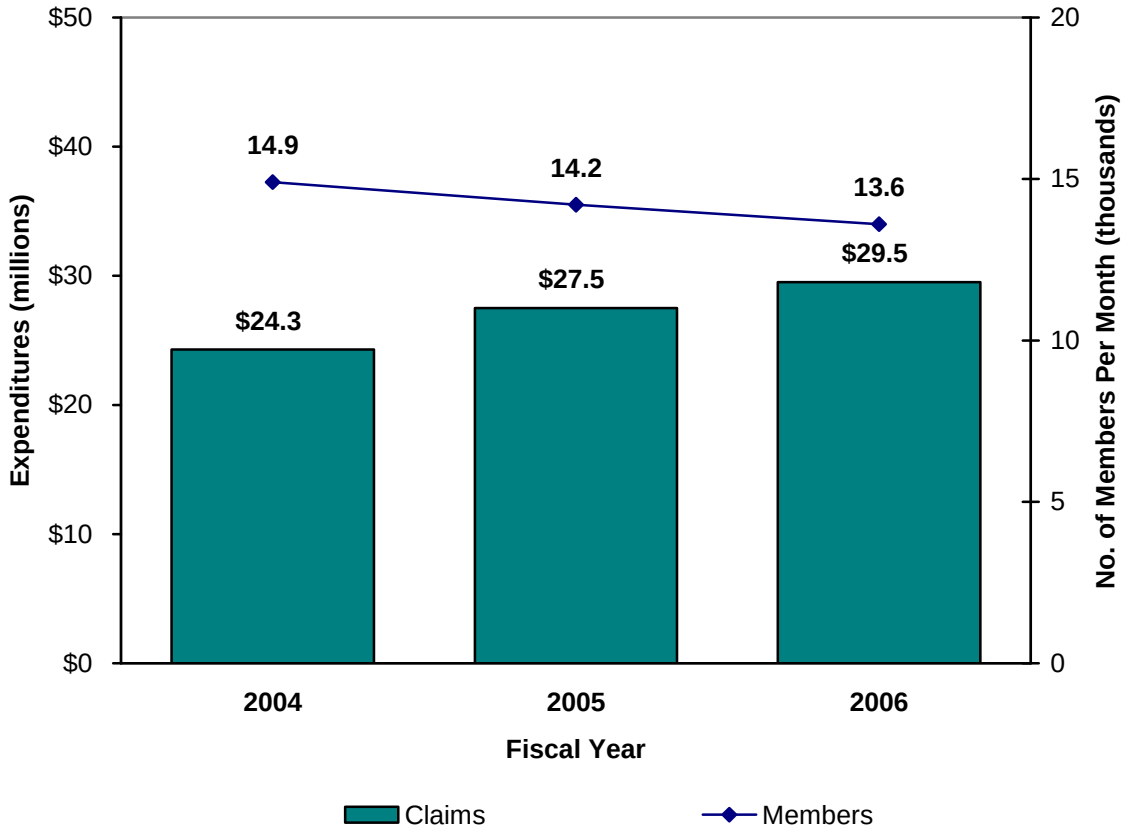
Source: Blue Cross of Idaho and Regence Blue Shield of Idaho.

Notes: Data are for city, county, and school district employee health plan contracts with Blue Cross of Idaho and Regence Blue Shield of Idaho only. Average number of members per month represents the sum of the total member months for each carrier divided by 12. Expenditures represent the sum of all claims incurred during each fiscal year and paid through May 2007 by each carrier.

Figure 21 presents combined enrollment and medical expenditures for Idaho's city, county, and school district employee health plans (with Blue Cross of Idaho and Regence Blue Shield of Idaho) for FYs 2004-2006. Over this time period, medical expenditures increased by $44.2 million or 32.9%, while member months decreased slightly by 3.9%.

The following three figures present enrollment and expenditures for city, county and school district employee health plans separately.

Figure 22. City Employee Health Plans in Idaho: Medical Expenditures and Enrollment (FY 2004-2006)

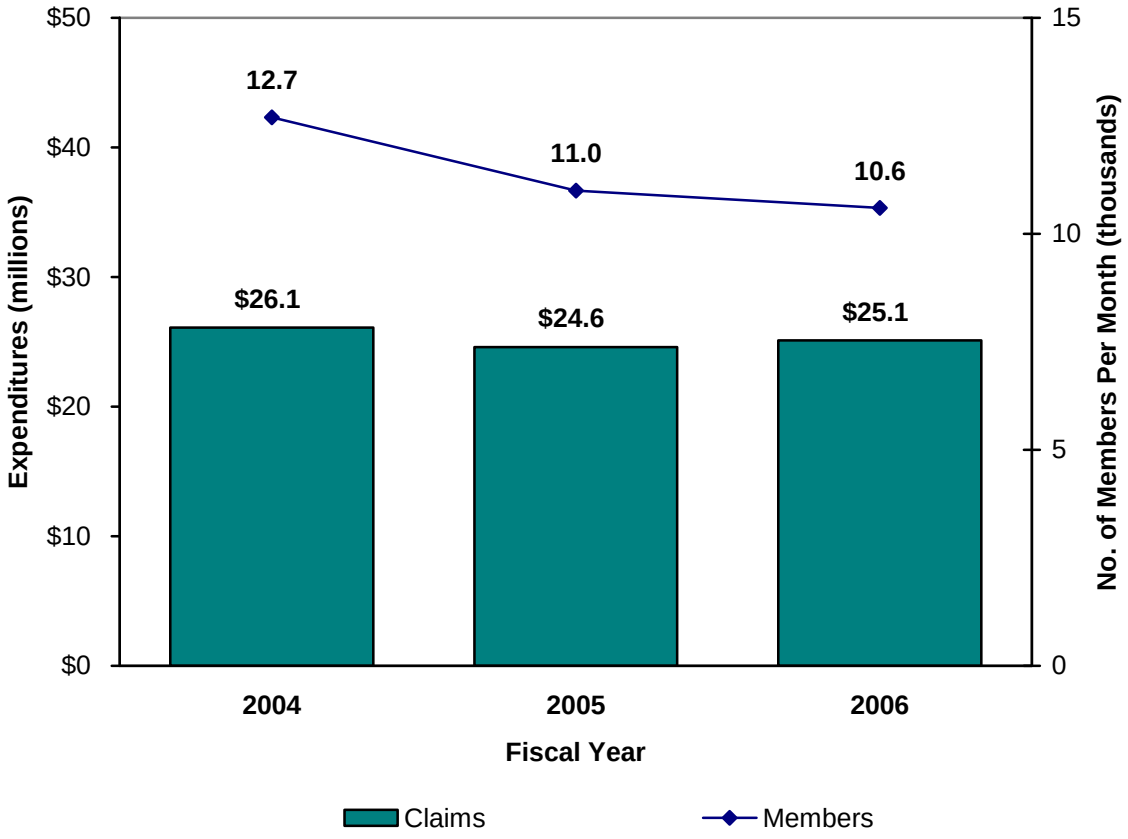


Source: Blue Cross of Idaho and Regence Blue Shield of Idaho.

Notes: Data are for city employee health plan contracts with Blue Cross of Idaho and Regence Blue Shield of Idaho only. Average number of members per month represents the sum of the total member months for each carrier divided by 12. Expenditures represent the sum of all claims incurred during each fiscal year and paid through May 2007 by each carrier.

Figure 22 first shows the enrollment and medical expenditures (combined for both carriers) for city employee health plans for FY 2004-2006. City employee medical expenditures increased by $5.2 million or 21.4% from FY 2004 through 2006, while member months have decreased by 9.2% over this time period. In FY 2006, city employees represented 18.0% of enrollment and 16.5% of medical expenditures for the local public employee health plans presented in this report.

Figure 23. County Employee Health Plans in Idaho: Medical Expenditures and Enrollment (FY 2004-2006)

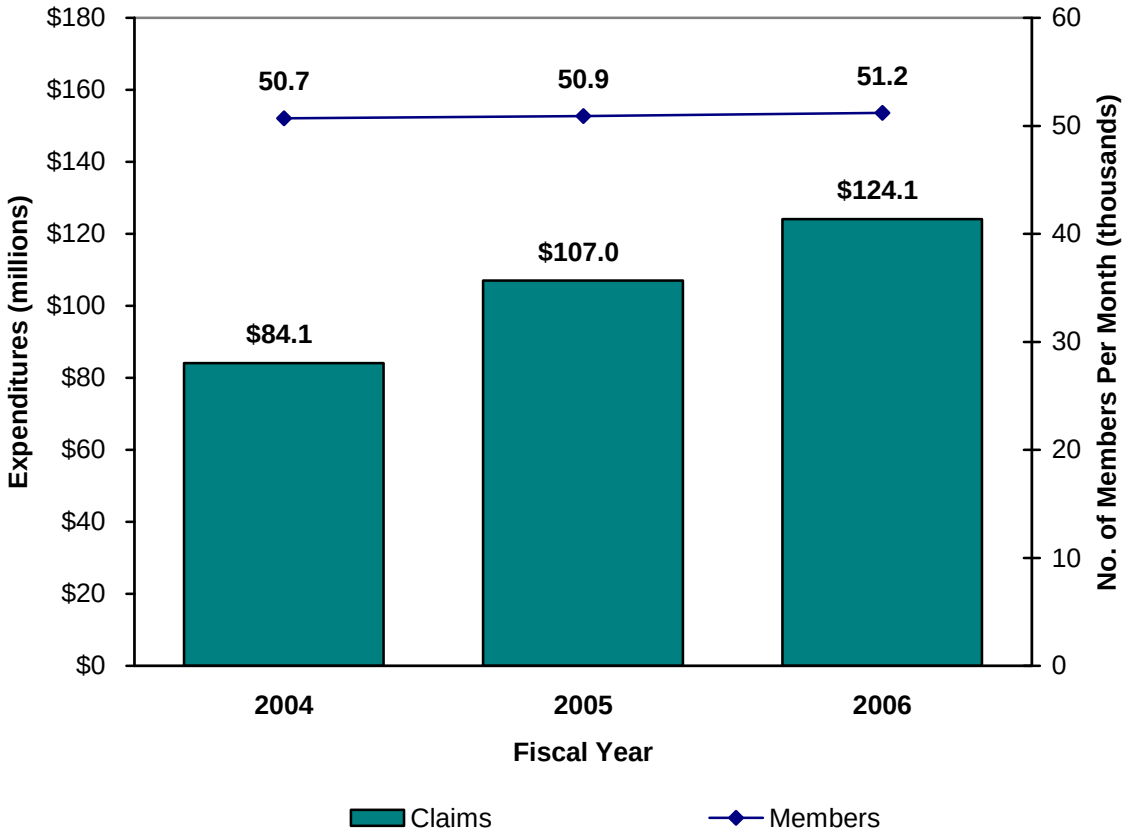


Source: Blue Cross of Idaho and Regence Blue Shield of Idaho.

Notes: Data are for county employee health plan contracts with Blue Cross of Idaho and Regence Blue Shield of Idaho only. Average number of members per month represents the sum of the total member months for each carrier divided by 12. Expenditures represent the sum of all claims incurred during each fiscal year and paid through May 2007 by each carrier.

Figure 23 presents the enrollment and medical expenditures for Idaho's county employee health plans for FYs 2004-2006. County employee medical expenditures decreased in FY 2005, but in FY 2006, these expenditures increased slightly by $0.5 million. Member months on the other hand show a consistent decline over this time period (as with the city plans). Overall, medical expenditures decreased by $1 million or 3.7% while member months decreased by 16.7%. In FY 2006, county employees represented 14.1% of enrollment and 14.0% of medical expenditures for the local public employee health plans presented in this report.

Figure 24. School District Employee Health Plans in Idaho: Medical Expenditures and Enrollment (FY 2004-2006)

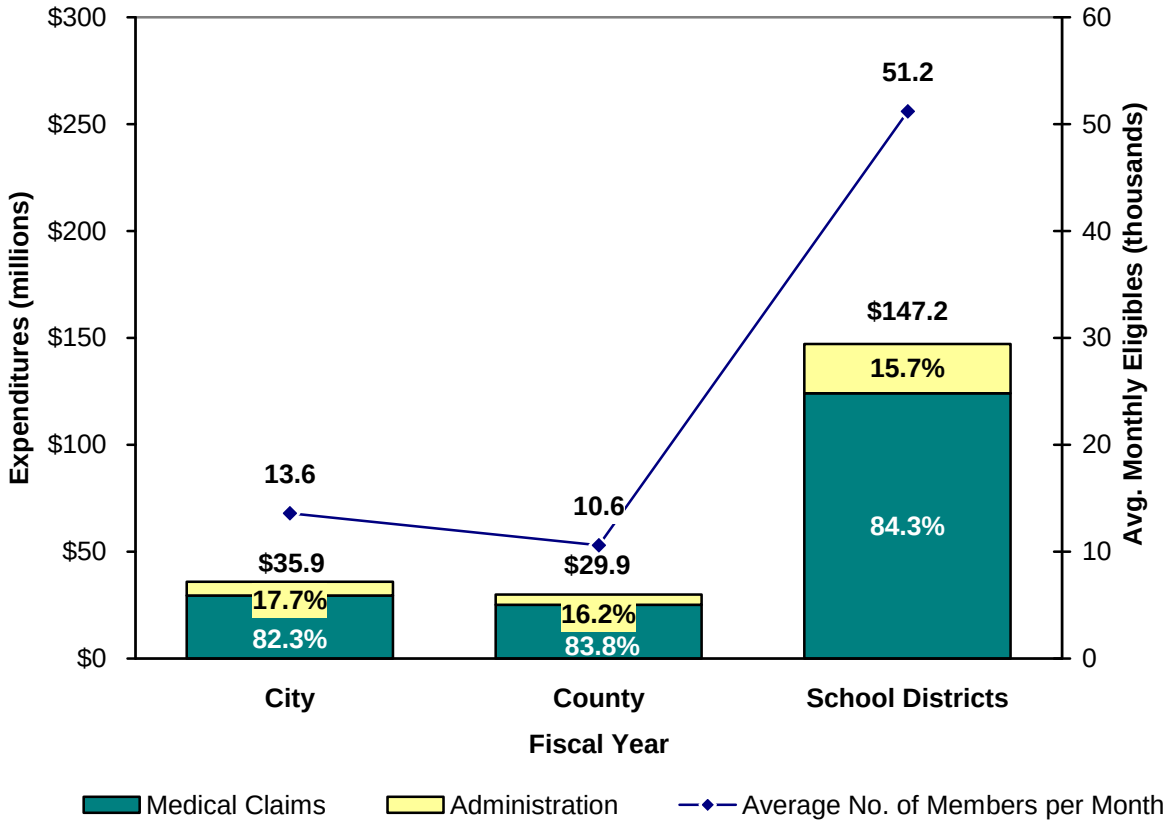


Source: Blue Cross of Idaho and Regence Blue Shield of Idaho.

Notes: Data are for school district employee health plan contracts with Blue Cross of Idaho and Regence Blue Shield only. Average number of members per month represents the sum of the total member months for each carrier divided by 12. Expenditures represent the sum of all claims incurred during each fiscal year and paid through May 2007 by each carrier.

Figure 24 shows enrollment and medical expenditures for Idaho's school district employee health plans for FYs 2004-2006. School district employee medical expenditures increased by $40 million, or 47.6% over this time period. Unlike city and county plans, school district member months did not fluctuate meaningfully between FYs 2004 and 2006. In FY 2006, school district employees represented 68.0% of enrollment and 69.4% of medical expenditures for the local public employee health plans presented in this report.

Figure 25. City, County, and School District Employee Health Plans in Idaho: Expenditures by Type and Total Enrollment (FY 2006)



Source: Blue Cross of Idaho and Regence Blue Shield of Idaho.

Notes: Data are for city, county, and school district employee health plan contracts with Blue Cross of Idaho and Regence Blue Shield of Idaho only. Average number of members per month represents the sum of the total member months for each carrier divided by 12. Expenditures represent the sum of all claims incurred during FY 2006 and paid through May 2007 by each carrier. Administration costs include general administrative expenses and claims adjustment expenses including costs containment expenses. Data are only available for FY 2006.

Figure 25 represents the share of medical and administration expenditures for city, county, and school district employee health plans for 2006. Data on member months also are presented. As stated before, data reported are combined for both carriers. Across all three local units of government, medical expenditures account for over 82% of total expenditures, the balance made up by administration. It is of interest to note that while city employee health care-related expenses fell in between county and school district medical expenditures, the proportion of city plan expenses related to administration was higher. In contrast, school districts, which yield the most members for Blue Cross of Idaho and Regence Blue Shield, entailed slightly higher medical expenses and relatively lower administrative expenditures.

Medical Expenditures by Service Type: Local Public Employee Medical Plans

Table 9. City, County, and School District Employee Health Plans in Idaho: Medical Expenditures by Service Type (FY 2004-2006)

	2004		2005		2006	
Service Type	$ (millions)	%	$ (millions)	%	$ (millions)	%
Hospital Care	$65.7	38.8%	$78.1	39.7%	$85.8	39.0%
Physician/Clinical & Other Professional Services	$44.2	26.1%	$57.0	29.0%	$60.8	27.7%
Prescription Drugs	$40.7	24.1%	$41.1	20.9%	$43.3	19.7%
Dental Services	$8.3	4.9%	$8.8	4.5%	$10.0	4.5%
Other	$7.8	4.6%	$8.3	4.2%	$16.3	7.4%
Durable Medical Products	$1.3	0.8%	$1.6	0.8%	$1.8	0.8%
Mental Health	$1.1	0.6%	$1.0	0.5%	$1.0	0.4%
Nursing Home & Home Health Care	$0.8	0.5%	$0.9	0.5%	$0.8	0.3%
Total	$169.9	100.0%	$196.9	100.0%	$219.7	100.0%

Source: Blue Cross of Idaho and Regence Blue Shield of Idaho.

Notes: Data are for city, county, and school district employee health plan contracts with Blue Cross of Idaho and Regence Blue Shield of Idaho only. Expenditures represent the sum of all claims incurred during each fiscal year and paid through May 2007 by each carrier. Expenditures on other non-durable medical equipment were not available.

Table 9 presents the breakdown of local employee medical expenditures by service type for both the carriers combined for FY 2004-2006. Hospital care, physician/clinical and other professional services, and prescription drugs made up the largest shares of medical expenditures all three years. During the three-year period, the share of medical expenditures attributable to prescription drugs decreased by 18.3% over this time period.

Medical Expenditures by Diagnostic Category: Local Public Employee Medical Plans

Table 10. County Employee Health Plan: Expenditures Associated with Top 5 Shared Costliest Diagnoses (FY 2004-2006)

Diagnostic Category	2004 (millions)	2005 (millions)	2006 (millions)
Musculoskeletal System & Connective Tissue	$2.5	$2.2	$1.8
Factors Influencing Health Status	$1.6	--	--
Circulatory System	$1.3	$1.3	$1.1
Digestive System	$1.3	$1.4	$0.8
Respiratory System	$1.0	$0.8	--
Genitourinary System	--	$0.7	$0.4
Nervous System & Sense Organs	--	--	$0.5

Source: Blue Cross of Idaho and Regence Blue Shield of Idaho.

Notes: Data are for county employee health plan contracts with Blue Cross of Idaho and Regence Blue Shield of Idaho only. Expenditures presented are based on ICD-9 Major Diagnostic Categories (MDCs). Expenditures represent all claims incurred during each fiscal year and paid through May 2007 by each carrier.

Table 11. City Employee Health Plan: Expenditures Associated with Top 5 Shared Costliest Diagnoses (FY 2004-2006)

Diagnostic Category	2004 (millions)	2005 (millions)	2006 (millions)
Musculoskeletal System & Connective Tissue	$2.5	$2.5	$2.2
Circulatory System	$1.4	$1.2	$0.8
Digestive System	$1.0	$1.1	$1.2
Nervous System & Sense Organs	$0.8	$0.8	--
Respiratory System	--	$0.8	$0.9
Genitourinary System	$0.8	--	$1.0

Source: Blue Cross of Idaho and Regence Blue Shield of Idaho.

Notes: Data are for city employee health plan contracts with Blue Cross of Idaho and Regence Blue Shield of Idaho only. Expenditures presented are based on ICD-9 Major Diagnostic Categories (MDCs). Expenditures represent all claims incurred during each fiscal year and paid through May 2007 by each carrier.

Table 12. School District Employee Health Plan: Expenditures Associated with Top 5 Shared Costliest Diagnoses (FY 2004-2006)

Diagnostic Category	2004 (millions)	2005 (millions)	2006 (millions)
Musculoskeletal System & Connective Tissue	$5.6	$6.7	$7.8
Circulatory System	$3.4	$4.5	$5.0
Digestive System	$2.5	$3.0	$4.1
Respiratory System	$1.5	$1.5	--
Genitourinary System	--	--	$1.7
Nervous System & Sense Organs	$1.4	$1.8	$1.9

Source: Blue Cross of Idaho and Regence Blue Shield of Idaho.

Notes: Data are for school district employee health plan contracts with Blue Cross of Idaho and Regence Blue Shield of Idaho only. Expenditures are based on ICD-9 Major Diagnostic Categories (MDCs). Expenditures represent all claims incurred during each fiscal year and paid through May 2007 by each carrier.

Tables 10-12 above summarize the top five costliest diagnostic categories for city, county, and school district health plans (shared by both Blue Cross of Idaho and Regence Blue Shield of Idaho) for FYs 2004-2006. For all three local public employee groups, musculoskeletal & connective tissue, circulatory, digestive, genitourinary, respiratory, and nervous system health problems are the most expensive diagnostic groupings. Factors influencing health status also was a costly diagnostic category for county employee health plans in FY 2004.

Highlights – Local Public Employee Health Plans

- From FY 2004-2006, overall medical expenditures for local employees/retirees (city, county and school districts) increased by $44.2 million or 32.9%, while member months decreased slightly by 3.9%. In FY 2006, medical expenditures amounted to $178.7 million, and enrollment totaled 75,331 members per month.
- Across all three local units of government, medical expenditures accounted for over 82% of total expenditures in 2006, the balance made up by estimated administration expenditures. Administration expenses were relatively highest for city employee health plans (17.7% of the total expenditures) and the lowest (15.7%) for school district employee plans.
- Hospital care, physician/clinical and other professional services, as well as prescription drugs were consistently the top three most expensive service categories for local public employee health care plans between FYs 2004 and 2006.
- During FYs 2004-2006, the musculoskeletal system and connective tissue diagnostic category was the costliest for local employee health plans.

SAFETY NET PROGRAMS:
COUNTY MEDICAL INDIGENCY PROGRAM

COUNTY MEDICAL INDIGENCY PROGRAM

Program Description

Historically, counties in Idaho have been responsible for the provision and payment of health care for its adult and child residents who lack adequate resources. Over time, this financial commitment became more formalized, whereby the county medical indigent program provided financial assistance for medical care expenditures. In 1991, the state Catastrophic Health Care Cost Program (hereafter called the State Catastrophic Program) was established to assist counties with payments in excess of $10,000 (discussed further in the next section). Now, county-level provision is incident-based, and counties are responsible for paying the medical bills under $10,000 in a 12-month period for each eligible indigent. The county and state program are intended for residents who require "medically needy services" but lack the income and resources to pay for the services.

The county program is partly funded through local property tax revenues as well the Idaho Millennium Income Fund (created from the tobacco company master settlement funds) which is used to reimburse or reduce the county deductible from $10,000 to $5,000 for tobacco-related medical bills. To receive county medical assistance, residents are required to complete an application form. At the time of application, an automatic lien is placed on an applicant's property. Under state law, recipients must make reimbursement payments to the county, and a county is able to recover costs from a recipient following death via his/her estate. Reimbursements are collected by the county and divided between the county and state in proportion to the claims paid by the county medical indigent program and the state Catastrophic Program.

Data Sources

SHADAC obtained data on the County Medical Indigency Program from two sources—the state Catastrophic Program Annual Reports from the Contract Administrator of this program and the Idaho Association of Counties (IAC). Data on county-level expenditures are collected separately by these two entities on an annual basis.

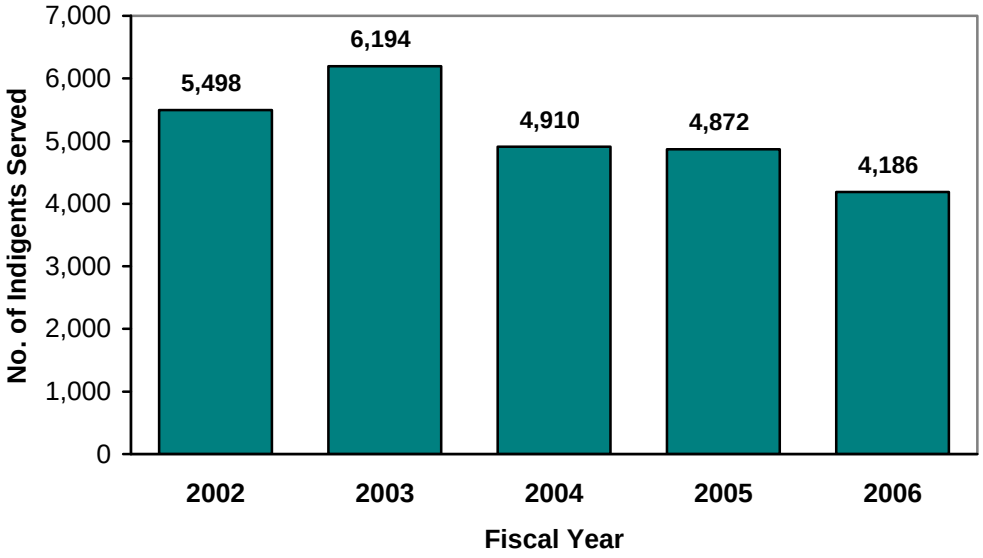
Under the Idaho statute, counties are required to annually report to the administrator of the state Catastrophic Program the following information for each county applicant: case number; dates of service; age; residence; sex; diagnosis; income; family size; amount of costs incurred including provider, legal and administrative charges; approval or denial; and reasons for denial. In fulfilling this requirement, the Catastrophic Program administrator sends a survey to each county each year and summarizes the results of the returned county reports in the annual report of the Catastrophic Program. While county response rate is 100%, there are nonetheless limitations to these data, namely inconsistency in reporting (e.g., whether just county expenditures are included or whether state cases are too). Due to the likely inconsistency in reporting, the contract administrator assumes an underreporting of total expenditures. For this report, we rely on the state Catastrophic Annual Reports for data on the number of indigents served as well as diagnosis trends. These data are for 2002-2006 and based on a state FY timeframe. More information about these reports is provided in the next section.

For each county fiscal year (CFY, October – September), the IAC requests summary financial information from all counties for a report to the state DHW. As part of this effort, the IAC requests total county indigent medical spending from each county. While there seems to be less confusion about the content of what is reported by counties to the IAC, an important limitation to these data is incomplete response by counties. The IAC conducts limited follow-up with counties. Therefore, each year, some counties do not report the requested information. For the non-participating counties, IAC consults with the counties and examines past information to produce estimates of the missing county indigent medical spending. For this report, we have included total county medical expenditures as estimated by the IAC for CFY 2004-2006.

Findings

Indigents Served: County Medical Indigency Program

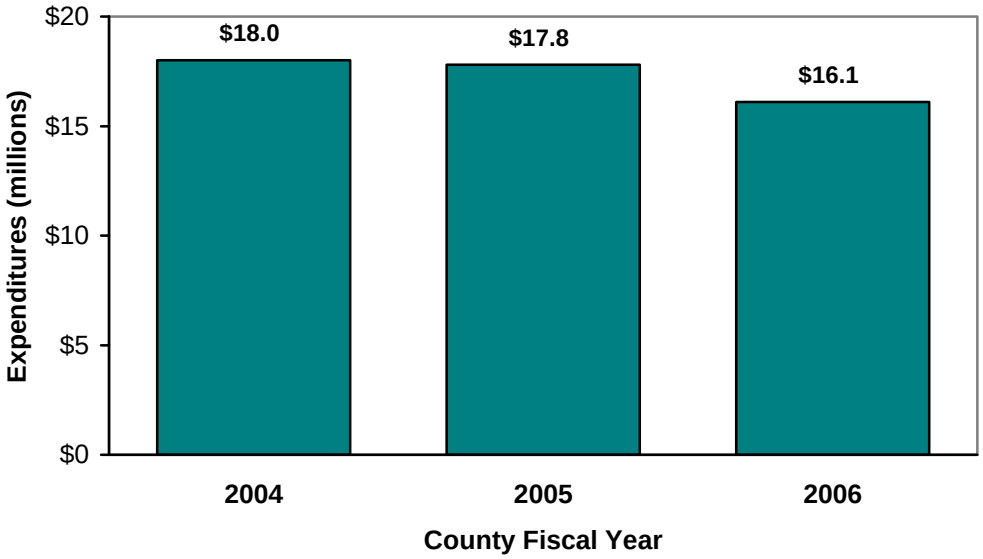
Figure 26. Idaho's County Medical Indigency Program: Indigents Served (FY 2002-2006)



Source: Catastrophic Health Care Cost Program, Annual Reports, 2002-2006.

Figure 26 presents the number of individuals served at the county level. After a boost in FY 2003, the number of indigents served has been on a decline in the last few years. Between FYs 2002 and 2006, the number dropped by 23.9% from 5,498 to 4,186 individuals.

Figure 27. Idaho's County Medical Indigency Program: Estimated Medical Expenditures (CFY 2004-2006)



Source: Estimates were provided by the Idaho Association of Counties.
Notes: Estimates for CFYs 2002 and 2003 were not available.

Figure 27 presents the estimated medical spending by counties between CFYs 2004 and 2006. Similar to program enrollment (Figure 21), these expenditures have decreased since CFY 2004. In CFY 2006, counties spent a total of $16.1 million in medical spending through their County Medical Indigency Programs, down 10.5% from the 18.0 million they spent in CFY 2004.

Indigents by Diagnoses: County Medical Indigency Program

Table 13. Idaho's County Medical Indigency Program: Indigents by Select Diagnostic Groups (FY 2002-2006)

Diagnostic Group	2002		2003		2004		2005		2006	
	#	%	#	%	#	%	#	%	#	%
General	2,585	47.0%	2,740	44.2%	1,489	30.3%	1,377	28.3%	986	23.6%
Mental Health	1,016	18.5%	1,256	20.3%	1,374	28.0%	1,237	25.4%	852	20.4%
Accident General	461	8.4%	527	8.5%	496	10.1%	514	10.6%	386	9.2%
Digestive System	434	7.9%	425	6.9%	431	8.8%	461	9.5%	785	18.8%
Coronary	321	5.8%	354	5.7%	333	6.8%	396	8.1%	353	8.4%
Cancer	212	3.9%	208	3.4%	221	4.5%	312	6.4%	319	7.6%
Respiratory	133	2.4%	128	2.1%	112	2.3%	144	3.0%	104	2.5%
Accident Vehicle	120	2.2%	125	2.0%	138	2.8%	125	2.6%	115	2.7%
Chronic Disease	94	1.7%	329	5.3%	192	3.9%	163	3.3%	113	2.7%
Infectious Disease	57	1.0%	48	0.8%	51	1.0%	61	1.3%	69	1.6%
Birth	42	0.8%	34	0.5%	39	0.8%	56	1.1%	78	1.9%
Neurology	23	0.4%	20	0.3%	34	0.7%	26	0.5%	26	0.6%
Total	5,498	100.0%	6,194	100.0%	4,910	100.0%	4,872	100.0%	4,186	100.0%

Source: Catastrophic Health Care Cost Program, Annual Reports, 2002-2006.

Table 13 shows the number and percent of medical indigents served for select diagnosis categories. The general diagnosis category (including stroke-, appendectomy-, gall bladder-related diagnoses) and mental health category account for the largest share of indigents across all years. Between FYs 2002 and 2006, there was an overall decrease in the percentage of indigents in the general diagnosis category. In contrast, at least some growth was observed in the proportion of individuals needing medical care in most other categories.

Highlights – County Medical Indigency Program

- Based on the available data, the County Medical Indigency Program is experiencing a declining trend in the number of medical indigents served and in medical expenses in recent years. Between FYs 2002 and 2006, the number of indigents served dropped by 23.9% to 4,186 individuals. In CFY 2006, county medical spending was estimated to be at $16.1 million, a decrease of 10.5% from CFY 2004.
- Almost 45% of indigents fell into the general and mental health diagnosis categories in FY 2006.
- Between FYs 2002 and 2006, there was an overall decrease in the percentage of indigents in the general diagnosis category. Some growth was observed in the proportion of individuals needing medical care in most other diagnostic categories.

SAFETY NET PROGRAMS:
STATE CATASTROPHIC HEALTH CARE COST PROGRAM

STATE CATASTROPHIC HEALTH CARE COST PROGRAM

Program Description

In 1991, the Idaho Legislature established the state Catastrophic Health Care Cost Program to share financial responsibility for payment of medical bills with the counties and to provide property-tax relief to its residents. This medical indigency program is a unique state-county partnership in which medical bills in excess of $10,000 within a 12-month period are referred to and paid for by the state Catastrophic Program. Under Idaho Code, not all medical services are reimbursed; the state Catastrophic Program pays only for the "medically needy services." Counties have the discretionary power to pay for services other than those considered medically necessary, but they are ineligible for reimbursement from the state Catastrophic Program.

Substantial state general fund dollars (including supplemental appropriations), along with the Millennium Income Fund and other sources, finance the state Catastrophic Program. A relatively recent source of funding for the program is seat belt income, which has been available since the beginning of July 1, 2003. Through this funding source, the state Catastrophic Program receives from the counties $5.00 of every $10.00 in seat belt fine violations collected under Idaho Code §49-673. Additionally, the program is designed such that beneficiaries are required to reimburse both the state and the counties on a prorated basis for the medical expenses based on income and resources. Once beneficiaries apply for assistance, the county attaches an automatic lien on their real and personal property and sets a reasonable schedule for repayments. The program has received reimbursement monies on many of the claims for which it has paid. A major share of these monies comes from the medically indigent themselves, and some comes from other governmental entities or third-parties (e.g., Medicaid). These monies are placed back into the fund for subsequent use. The state Catastrophic Program is administered by a seven-member board and a Contract Administrator assists in processing claims.

Data Sources

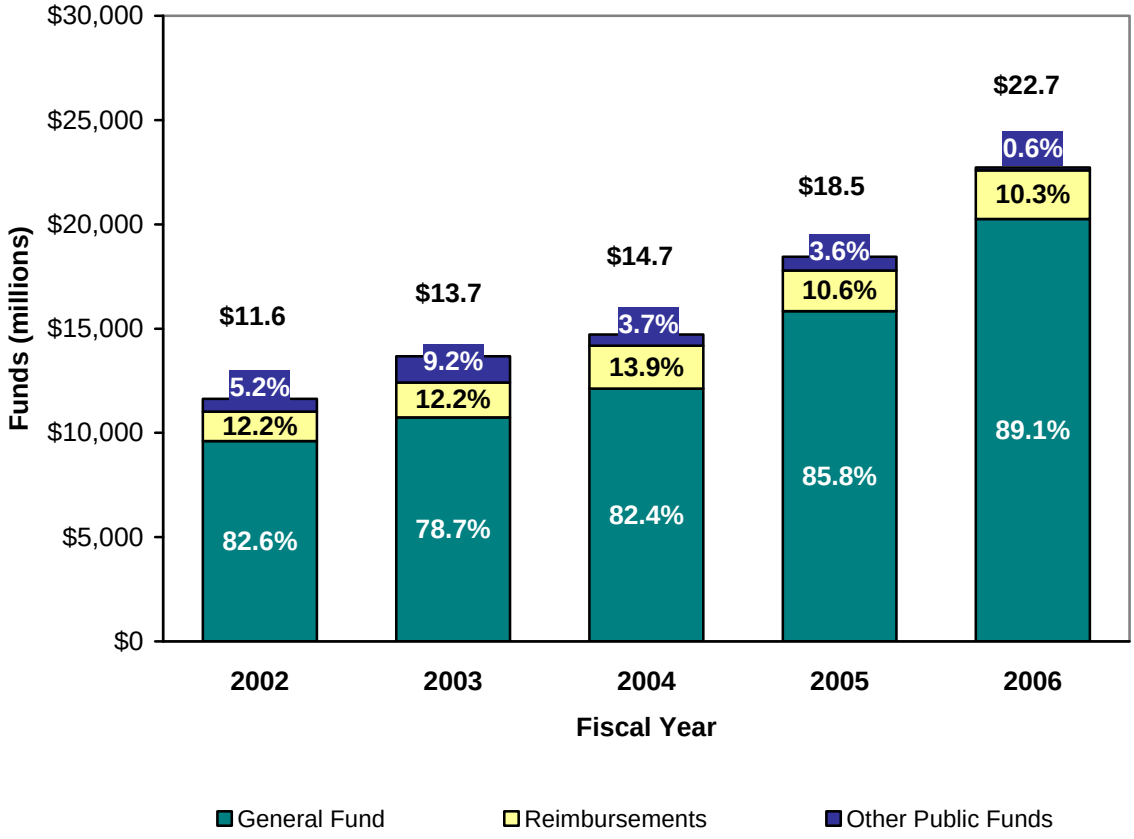
Most of the data presented in this section of the report were provided by the Office of the Contract Administrator for the state Catastrophic Program in the form of annual reports. These reports are completed on a fiscal year basis and include details on medical payments to providers, the number of individuals served, the amount received by the program in reimbursements, funding allocations made to the state Catastrophic Program, and audited financial statements. The program annual reports also include a summary of the annual reports counties are required by law to submit to the state Catastrophic Program. We obtained state Catastrophic Program annual reports for FYs 2002-2006.

Additional data on state Catastrophic Program expenditures by diagnosis were provided from the Idaho Office of the State Controller for FY 2005-2006.

Findings

Composition of Program Financing: State Catastrophic Program

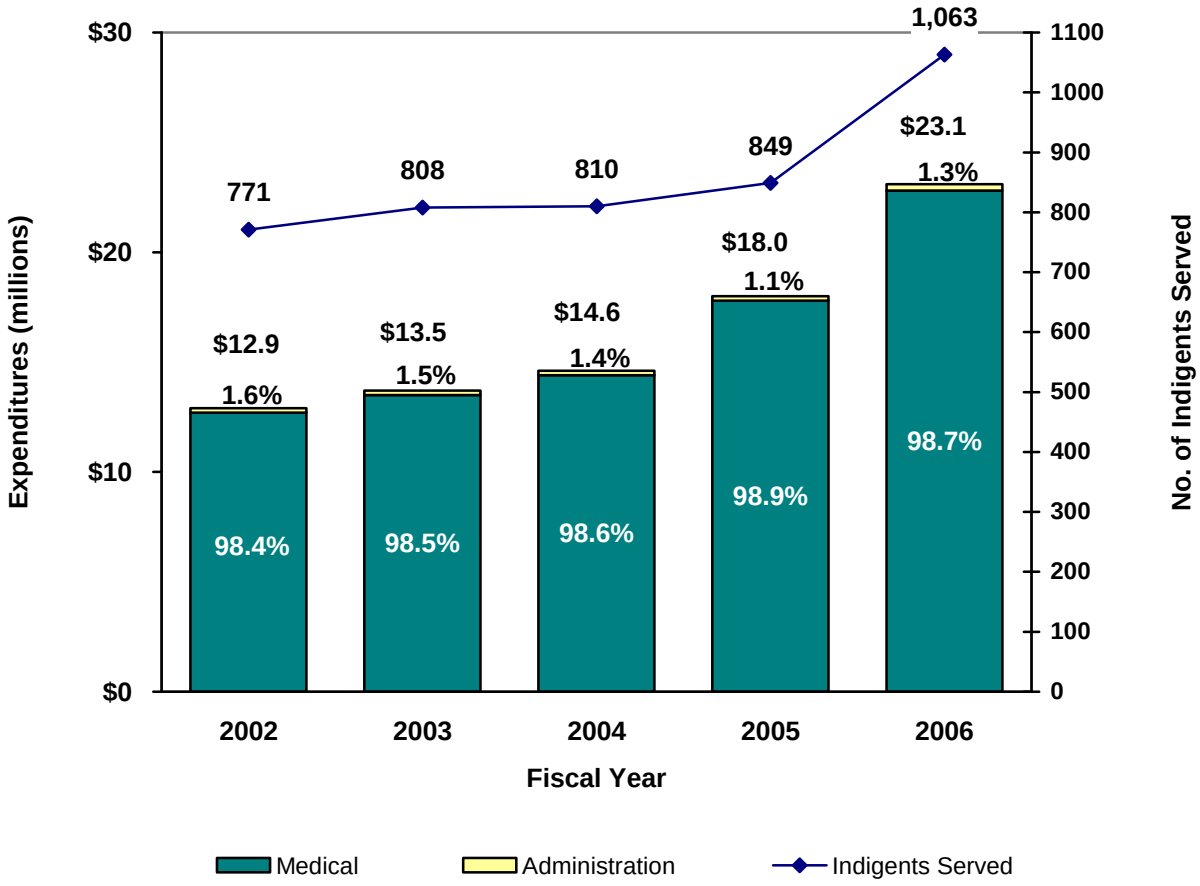
Figure 28. Idaho's State Catastrophic Program: Funding by Source (FY 2002-2006)



Source: Catastrophic Health Care Cost Program, Annual Reports, 2002-2006.
Notes: General Fund appropriations include supplemental funds when appropriated in FY 2003-2006. Other Public Funds include Millennium funds and Seat Belt Income from counties. Reimbursements include receipts from indigents, government entities or third-parties. Interest on investments is not included as a source of funding.

Figure 28 shows the growth in program funding and source of funds for the state Catastrophic Program for FYs 2002-2006. General fund (including supplemental) appropriations were the major source of financing for the program, and its role consistently increased during the five-year period. In 2006, these funds represented 89.1% of total funding compared to 82.6% in 2002 (a relative increase of about 7.9%). Reimbursements from program participants or third parties comprised the second largest share of program funding and since 2002, their share has declined (by 15.6%) to 10.3% of overall funds. Other public funds (the Idaho Millennium Income Fund and seat belt income from counties) have made up the balance of program funding, representing as high as 9.2% (FY 2003) and as low as 0.6% (FY 2006) of overall funds.

Figure 29. Idaho's State Catastrophic Program: Expenditures by Category and Indigents Served (FY 2002-06)



Source: Catastrophic Health Care Cost Program, Annual Reports, 2002-2006.

Notes: Medical expenditures include payments made to providers. Administration includes board travel; contract administration; overhead allocation; and other professional services. Expenditures do not account for reimbursements. Reimbursements received ranged over 10% from FY 2002-2006.

Figure 29 shows the number of individuals served and total medical and administrative expenses for the state Catastrophic Program for FYs 2002-2006. The number of individuals enrolled in the program grew consistently during the five years, from 771 to 1,063, for an increase of 37.9%. Not surprisingly, medical expenses also have been on the rise since FY 2002. In fact, they grew by 79.0%, from $12.7 million in FY 2002 to $22.8 million in FY 2006. Medical expenses' share of overall spending has remained fairly constant at 98%-99% over the years. Administrative expenses, just under 1.5% of total expenditures in FY 2006, also grew during this time frame, from $188,173 to $251,840, representing a 33.8% increase.

Medical Expenditures by Diagnoses: State Catastrophic Program

Table 14. Idaho's State Catastrophic Program: Expenditures by Diagnostic Category (FY 2005-2006)

Diagnostic Category	2005		2006	
	$ (thousands)	%	$ (thousands)	%
General	$4,879	26.7%	$6,072	26.7%
Cancer	$4,098	22.4%	$5,290	23.2%
Coronary	$4,070	22.3%	$3,957	17.4%
Accident-Vehicle	$1,629	8.9%	$2,023	8.9%
Chronic Disease	$1,391	7.6%	$2,167	9.5%
Accident-General	$1,310	7.2%	$2,214	9.7%
Mental Health	$525	2.9%	$875	3.8%
Birth	$240	1.3%	$132	0.6%
Infectious Disease	$129	0.7%	$40	0.2%
Total	$18,272	100.0%	$22,772	100.0%

Source: Idaho Office of the State Controller, categorized by SHADAC based on diagnosis groupings provided by the State Catastrophic Health Care Cost Program.

Notes: Categories were compiled using diagnostic codes provided by the Catastrophic Health Care Cost Program, Contract Administrator. Examples of diagnoses included in categories are stroke (General); Diabetes (Chronic Disease); alcoholic/drug related (Accident General); Hepatitis (Infectious Disease).

Table 14 presents medical expenditures by diagnosis category for the two most recent fiscal years. Expenditures were similar between the two years, with the general category (including diagnoses such as stroke, appendectomies, gall bladder) accounting for 26.7% of expenditures. The cancer and coronary categories also made up a fair share of medical expenditures. In FY 2006, cancer-related diagnoses accounted for 23.2% and coronary-related diagnoses accounted for another 17.4% of medical spending.

Highlights – State Catastrophic Program

- General fund (including supplemental) appropriations make up the major source of financing for the state Catastrophic Program, and its role has consistently increased between FYs 2002 and 2006, representing 89.1% of total funding in 2006. Reimbursements comprised the second largest share of program funding and, since FY 2002, their share has declined (by 15.6%) to 10.3% of overall funds.
- The number of individuals served by the program grew consistently during the five years, from 771 to 1,063, for an increase of 37.9%.
- Not surprisingly, medical expenses also have been on the rise since FY 2002, growing by 78.7%, to $22.8 million in FY 2006.
- Despite growth in program enrollment and medical expenditures, administrative expenditures have been consistently low, representing just under 1.5% of program expenditures.

- The general diagnostic category (e.g., stroke) and cancer accounted for the largest share of medical expenditures in FYs 2005 and 2006. While the percentage of medical expenditures attributable to coronary disease, birth, and infectious disease decreased between FY 2005 and 2006, increases in the share of medical expenditures for chronic disease, accidents, and mental health were observed.

SAFETY NET PROGRAMS:
IDAHO INDIVIDUAL HIGH RISK REINSURANCE POOL

IDAHO INDIVIDUAL HIGH RISK REINSURANCE POOL

Program Description

High risk pools offer comprehensive health insurance benefits to individuals who are considered medically uninsurable. These individuals have been denied private coverage, can only avail restricted coverage, or are assessed higher premiums due to pre-existing medical conditions.

The Idaho Individual High Risk Reinsurance Pool was established by the Idaho Legislature and went into effect in 2001.[18] This high risk pool offers five plans—Basic, Standard, Catastrophic A, Catastrophic B, and Health Savings Account (HSA)-compatible plans with varying lifetime maximums, deductibles, coinsurance and associated out-of-pocket costs. Generally, individuals are eligible for the pool if they are under 65 years of age, do not have health insurance coverage and are ineligible for a group health plan or Medicaid and Medicare or if they are federally eligible under HIPAA.

Idaho's pool is "unique in that participating carriers underwrite and issue the individual High Risk Pool policies and maintain the traditional insurer/enrollee relationship."[19] All insurance carriers in the state approved to offer individual health benefit plans are required to offer the high risk pool products. Idaho's pool also is distinctive for its reinsurance component, which transfers some of the risk of its high-cost enrollees to a reinsurance pool. Insurers are responsible for the first $5,000 in individual claims, and the reinsurer is responsible for 10% of the next $25,000. All claims exceeding $25,000 are covered by the reinsurance pool, up to the lifetime maximums of the guaranteed issue products. Ameriben, Inc., a human resources and management consulting firm, is the administrator of the reinsurance pool.

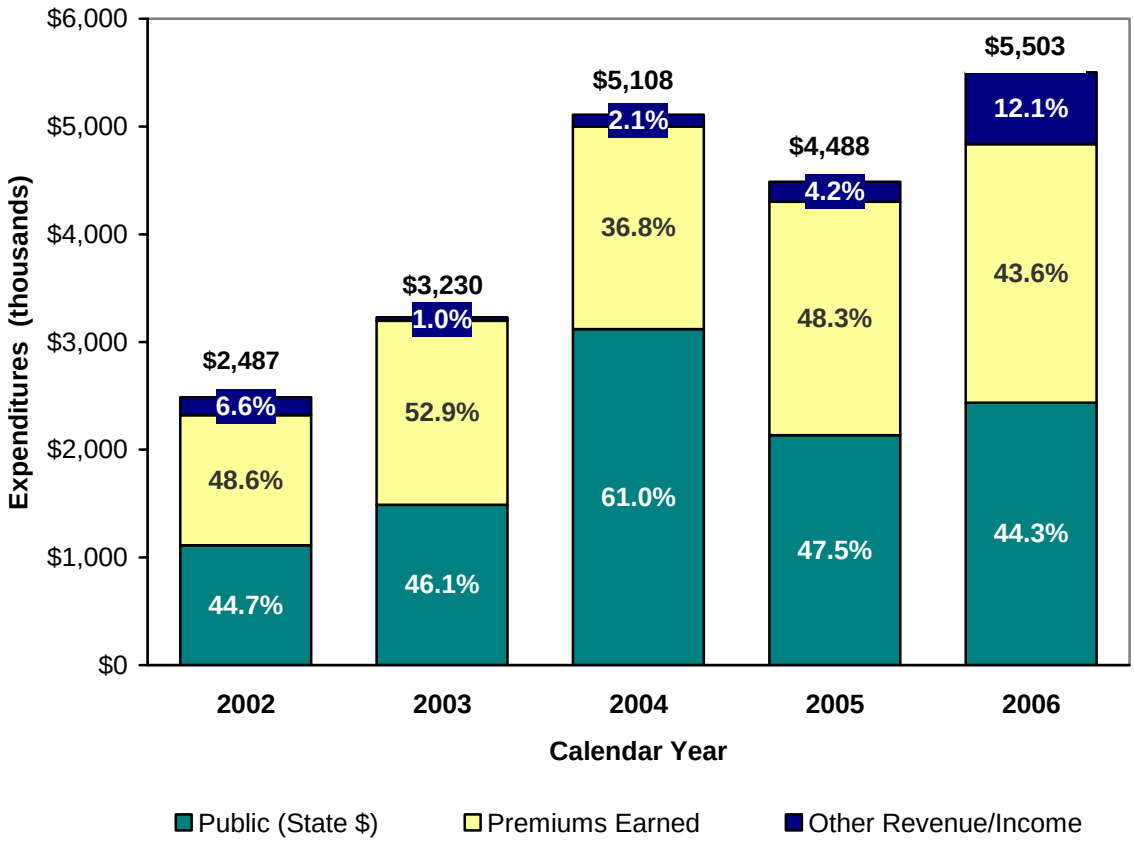
Data Sources

Data on the Idaho Individual High Risk Reinsurance Pool were provided by Ameriben, Inc. The pool administrator provided financial audit reports for the past five calendar years, 2002-2006. Details on pool financing, medical and administrative expenses, and pool enrollment are presented below.

Findings

Sources of Program Financing: High Risk Pool

Figure 30. Idaho Individual High Risk Reinsurance Pool: Expenditures by Funding Source (CY 2002-2006)



Source: Ameriben, Inc., Idaho Individual High Risk Reinsurance Pool Statements of Revenues, Expenses, and Changes in Net Assets, Years Ended December 31, 2002-2006.

Notes: Public dollars refer to deferred state tax revenue (premium tax dollars). Other Income/Revenue refers to carrier assessments (2002 only), penalty revenue (2003 only), interest income, and gains on investment.

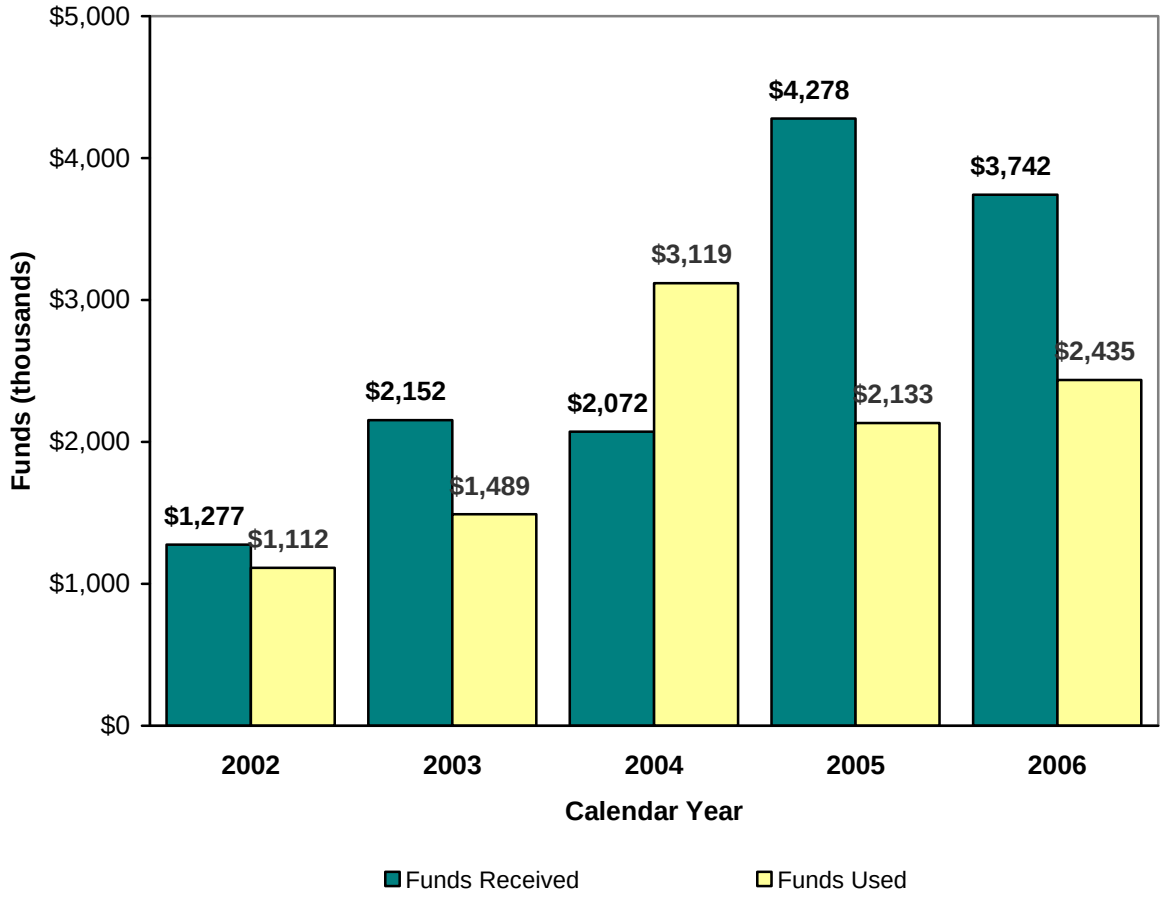
The reinsurance pool is funded through reinsurance premiums contributed by participating carriers, a portion of the state's premium tax revenue, and assessments from insurers, if required. Additionally, the program draws on interest income and gains on investments to offset costs. Each year, one-fourth of premium tax dollars collected by the state exceeding $45 million is directed to the pool and accrues in a deferred state tax revenue account. The funds are then used as necessary to offset losses, along with interest and investment income.

Figure 30 presents the total expenses incurred by the reinsurance pool along with the composition of revenue for CYs 2002 through 2006. Total expenses more than doubled in the five years, from $2.5 million in 2002 to $ 5.5 million in 2006. State tax revenue and reinsurance premiums have financed the large majority of expenditures, with each contributing about 44%

of total spending in 2006. In general, interest/investment income has contributed relatively little, although it offset 12.1% of the pool expenses in 2006. Initial assessments were applied to carriers and accommodated 5.3% of total pool expenses in 2002. Carrier assessments have not been required since.

State Contributions to Pool Financing: High Risk Pool

Figure 31. Idaho Individual High Risk Reinsurance Pool: State Funds Received and Used (CY 2002-2006)

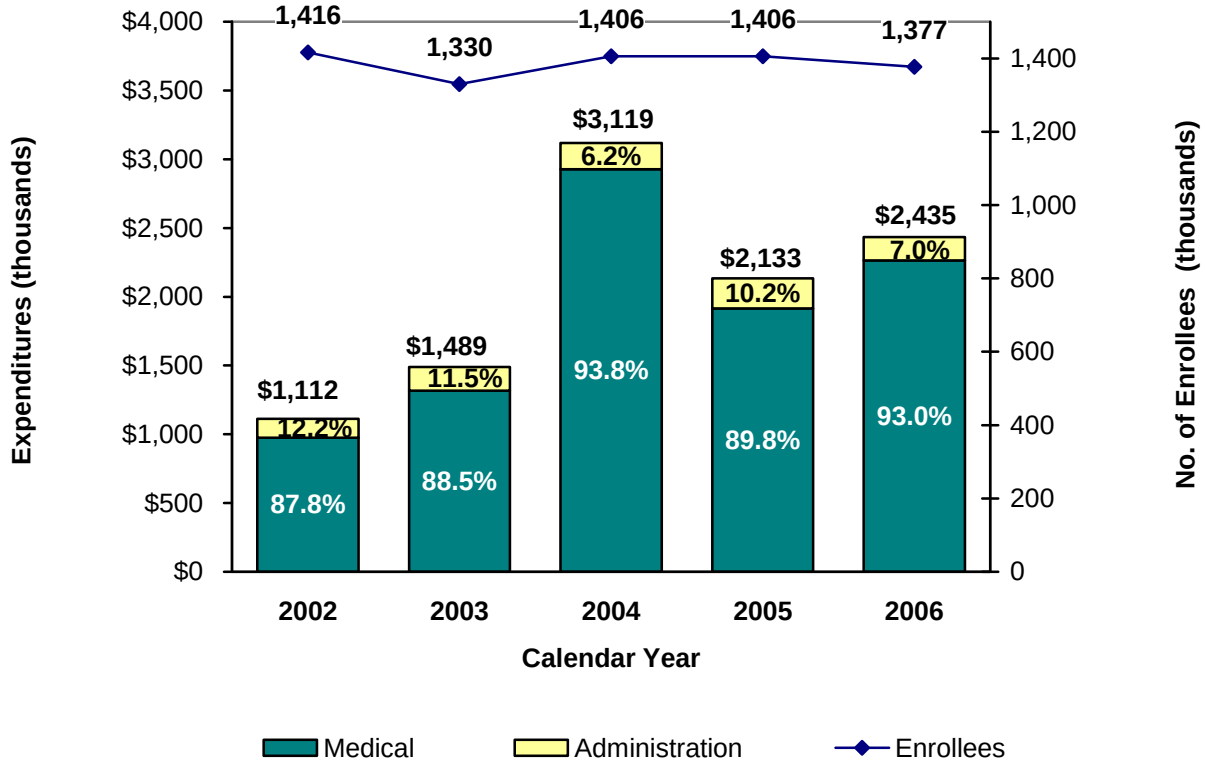


Source: Ameriben, Inc., Idaho Individual High Risk Reinsurance Pool Statements of Revenues, Expenses, and Changes in Net Assets, Years Ended December 31, 2002-2006.
Notes: State funds refer to income from the deferred state tax revenue.

Each year, one-fourth of premium tax dollars collected by the state exceeding $45 million are directed to the pool and accrue in a deferred state tax revenue account. The funds are then used as necessary to offset losses incurred by the pool. Figure 31 compares the state funds allocated to the pool with the amount ultimately required for each of the five years. In all years but 2004, state pool expenses were lower than the total deferred state tax dollars directed to the pool. The funds allocated to the pool in 2006 were almost triple the amount in 2002; the funds used in 2006 more than doubled the amount required in 2002.

Enrollment and Public Expenditures: High Risk Pool

Figure 32. Idaho Individual High Risk Reinsurance Pool: Estimated State Expenditures by Category and Enrollment (CY 2002-2006)

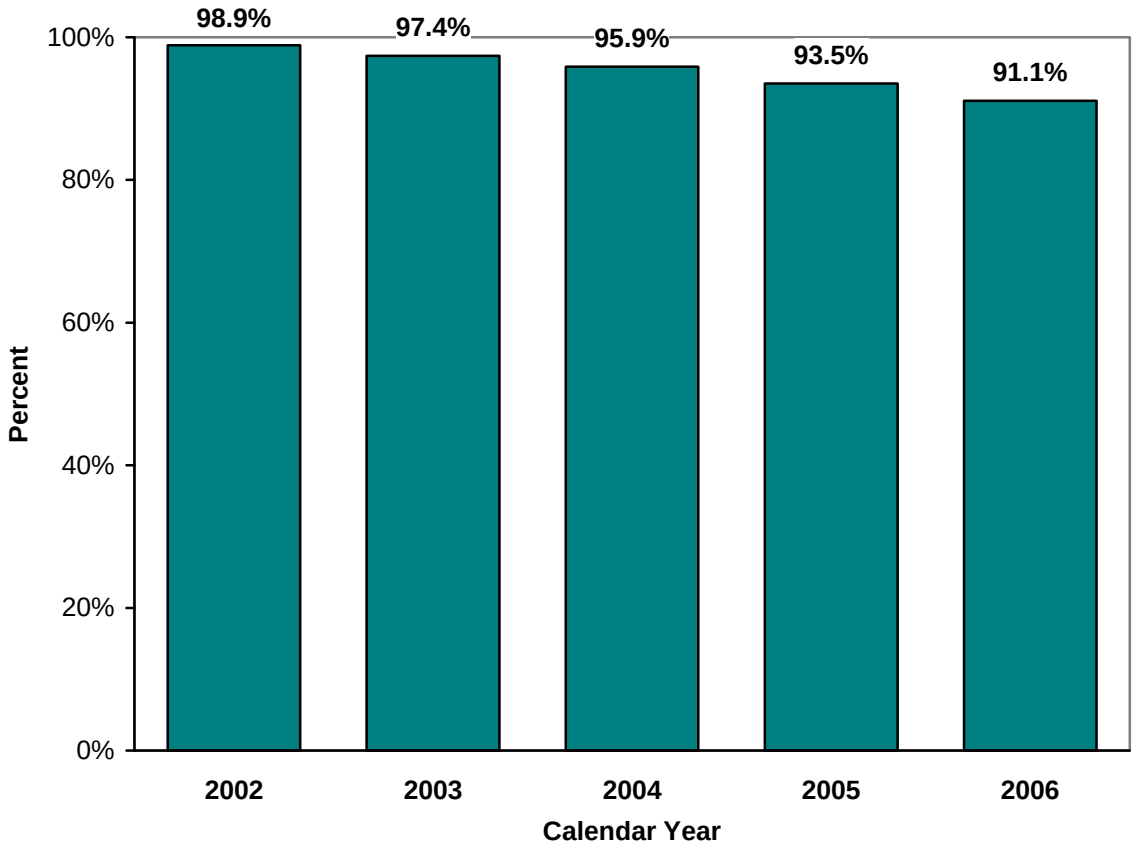


Source: Ameriben, Inc., Idaho Individual High Risk Reinsurance Pool Statements of Revenues, Expenses, and Changes in Net Assets, Years Ended December 31, 2002-2006. Enrollment data from Ameriben, Inc., Supplemental Information on Ceded Risks.

Notes: State spending on medical and administration were estimated using the relative shares of these expenses after accounting for the premiums paid and other revenue. Administration includes contract management services; professional fees; and other administrative expenses. Enrollment represents total lives enrolled as of January 20th of the following year.

Figure 32 provides the total number of individuals enrolled in the reinsurance pool for each of the calendar years along with the total amount used in state tax revenue to finance the medical and administrative expenses associated with the pool. Overall, the number of enrollees decreased slightly over time, from 1,416 to 1,377, or 2.8%. In contrast, funds needed from the deferred state tax revenue account to finance the program more than doubled from $1.1 million in 2002 to $2.4 million in 2006. As is shown in both Figures 31 and 32, the amount required from state tax revenue to offset costs in 2004 was particularly high. In 2002 and 2003, administrative expenses approximated 12% of state expenditures. In the three most recent years, administrative expenses are estimated to have comprised 10.2% or less of total state expenditures on the reinsurance pool.

Figure 33. Idaho Individual High Risk Reinsurance Pool: Blue Cross of Idaho's and Regence Blue Shield of Idaho's Combined Share of Total Enrollment (CY 2002-2006)



Source: Ameriben, Inc., Supplemental Information on Ceded Risks.
Notes: Enrollment represents total lives enrolled as of January 20th of the following year.

All insurance carriers in the state approved to offer individual health benefit plans are required to offer the high risk pool products. The majority of pool participants, however, have historically been enrolled through Blue Cross of Idaho or Regence Blue Shield of Idaho (see Figure 33). These two carriers' proportion of the high risk pool enrollment, however, has been on a consistent decline. Between 2002 and 2006, their enrollment share dropped by 7.9%, from 98.9% to 91.1%.

Table 15. Idaho Individual High Risk Reinsurance Pool: Enrollment by Plan Type (CY 2002-2006)

Plan Type	2002		2003		2004		2005		2006	
	#	%	#	%	#	%	#	%	#	%
Basic	161	11.4%	111	8.3%	99	7.0%	66	4.7%	49	3.6%
Standard	454	32.1%	405	30.5%	361	25.7%	325	23.1%	242	17.6%
Catastrophic A	263	18.6%	240	18.0%	246	17.5%	326	23.2%	219	15.9%
Catastrophic B	538	38.0%	574	43.2%	700	49.8%	689	49.0%	803	58.3%
Health Savings Account	--	--	--	--	--	--	--	--	64	4.6%
Total	1,416	100.0%	1,330	100.0%	1,406	100.0%	1,406	100.0%	1,377	100.0%

Source: Ameriben, Inc., Idaho Individual High Risk Reinsurance Pool Statements of Revenues, Expenses, and Changes in Net Assets, Years Ended December 31, 2002-2006. Enrollment data from Ameriben, Inc., Supplemental Information on Ceded Risks.

Notes: Enrollment represents total lives enrolled as of January 20th of the following year. Health Savings Account plan was not available until 2006.

Table 15 shows enrollment for all five pool products. Enrollment by each of the products has fluctuated over the years. Enrollment in the Catastrophic B plan (the highest deductible product available) increased by 49.3% since 2002 to include 803 or 58.3% of all pool participants in 2006. In contrast, participation in the basic, standard, and Catastrophic A plans (the lower deductible, higher coinsurance plans) has decreased considerably. Enrollment in these plans combined dropped from 878 to 510, representing a 41.9% decrease. The health savings account-compatible plan took effect in 2006 and represented approximately 5.0% of the total pool enrollment in its first year.

Highlights – High Risk Reinsurance Pool

- Overall, the number of individuals enrolled in the pool has decreased slightly over time, from 1,416 to 1,377, or 2.8%.
- Total expenses for the Idaho Individual High Risk Reinsurance Pool more than doubled in five years, from $2.5 million in 2002 to $ 5.5 million in 2006.
- State tax revenue and carrier reinsurance premiums have financed the large majority of expenditures, with each contributing about 44% of total spending in 2006.
- Funds needed from the deferred state tax revenue account to finance the program more than doubled from $1.1 million in 2002 to $2.4 million in 2006.
- Since 2002, administrative expenses have comprised no more than 12% of state expenditures on the reinsurance pool. In 2006, administration consumed 6.1% of state spending on the program.
- Between 2002 and 2006, there was a shift in enrollment from the lower deductible, higher coinsurance risk pool plans (Basic, Standard, and Catastrophic A plans) to the highest deductible product available (Catastrophic B plan).

SAFETY NET PROGRAMS:
COMMUNITY HEALTH CENTERS

COMMUNITY HEALTH CENTERS

Program Description

Community Health Centers (CHCs) are the safety net for the uninsured and the underinsured to access primary, mental and preventive services. In addition to health services, health centers also provide transportation, outreach, and community health education and wellness services. They are typically located in medically underserved areas; the users of these services are charged fees based on their ability to pay; and volunteer consumer boards govern these centers. The major sources of funding for these centers come from federal grants and indirect revenues generated from patient services. Federally, they are funded under Section 330 of the Public Health Service (PHS) Act. Based on the type of population served, health centers may receive a combination of section 330 grant funds which may be subdivided into three categories—330(e), aimed at serving diverse underserved populations; 330(g), aimed at serving migratory and seasonal farm workers and their families; and 330(h), aimed at serving homeless adults, families and children. [20]

In Idaho, there are ten health center organizations which include 30 clinics statewide and three clinics in Oregon that provide primary and preventive health care services. These organizations are the Boundary Regional Community Health Center (BRCHC)/Kaniksu Health Services; Drine Community Health Center; Benewah Medical Center; Adams County Health Center; Valley Family Health Care; Terry Reilly Health Services; Glenns Ferry Health Center; Family Health Services; Health West, Inc.; and Community Family Clinic. Idaho does not have school-based clinics or Primary Care Public Housing Health Centers. The Idaho Primary Care Association (IPCA) represents the ten health center organizations. The IPCA is a non-profit entity that strives to strengthen health center partnerships and promote a statewide network of primary care services for the medically vulnerable populations.

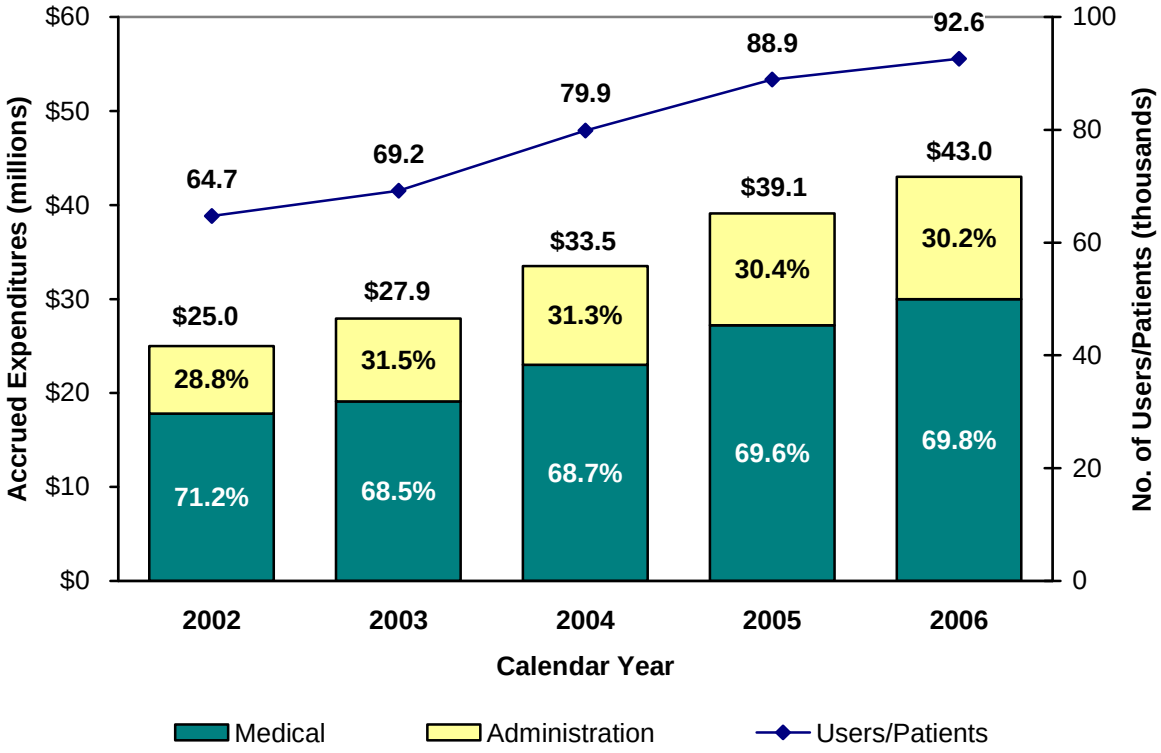
Data Sources

Data on health centers for 2002-2006 were provided by the IPCA in the form of annual summary Uniform Data System (UDS) Universal Reports for all clinics, which are based on reports the centers are required to generate and make available to the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). These reports are prepared on a calendar year (CY) basis and include comprehensive data on users/patients served, services provided, financing, etc. Because health centers are not required to report separate data on public and private medical expenditures, we are unable to separate those out for the purposes of this report. However, revenue amounts by private and public sources are available. General information about center patients/users and health expenditures is first presented below, followed by data on private and public sources of revenue.

Findings

Number of Users/Patients and Total Expenditures: CHCs

Figure 34. Idaho Community Health Centers: Accrued Expenditures by Category and Users/Patients Served (CY 2002-2006)



Source: UDS Universal Reports 2002-2006, provided by the Idaho Primary Care Association.

Notes: Medical expenditures refer to incurred costs. These include expenses for enabling services; however they exclude the value of donated services and supplies (value ranged from $1,971,535 in 2002 to $3,540,469 in 2005). Administration includes administrative expenses associated with medical services and enabling services (e.g., case management, transportation, community education, patient education) as well as facility-related expenses. Enrollment data include both public and private users/patients. Data for CY 2006 are preliminary.

Figure 34 presents the number of users/patients served and expenditures– both medical and administrative—accrued by CHCs for CYs 2002-2006. Overall, CHCs have experienced an increase in users/patients served and especially in expenditures. In 2002, $25.0 million in expenses were incurred to serve 64,714 patients, and in 2006, $43.0 million was accrued for 92,590 patients representing a growth of 43.1% in users and 71.4% in spending. During the five-year time span, administrative expenses grew by 79.7% between 2002 and 2006 and represent just under a third of total accrued costs. Administration takes into account facility-related expenses, which in CY 2005, amounted to $2.6 million or 21.9% of total administrative expenses.

Expenditures by Service Type: CHCs

Table 16. Idaho Community Health Centers: Accrued Expenditures by Service Type (CY 2002-2006)

Service Type	2002		2003		2004		2005		2006	
	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%
Medical Care	$12,138	68.2%	$12,806	67.2%	$15,188	66.1%	$18,091	66.4%	$19,805	66.2%
Pharmacy & Pharmaceuticals	$2,311	13.0%	$2,180	11.4%	$2,612	11.4%	$2,929	10.8%	$2,668	8.9%
Dental	$1,720	9.7%	$2,118	11.1%	$2,562	11.1%	$3,222	11.8%	$3,883	13.0%
Mental Health	$528	3.0%	$715	3.8%	$819	3.6%	$1,095	4.0%	$1,564	5.2%
Substance Abuse	--	--	$55	0.3%	$167	0.7%	$211	0.8%	$202	0.7%
Other Professional Services Including Enabling Services	$1,102	6.2%	$1,188	6.2%	$1,636	7.1%	$1,694	6.2%	$1,811	6.0%
Total	$17,800	100.0%	$19,062	100.0%	$22,985	100.0%	$27,243	100.0%	$29,932	100.0%

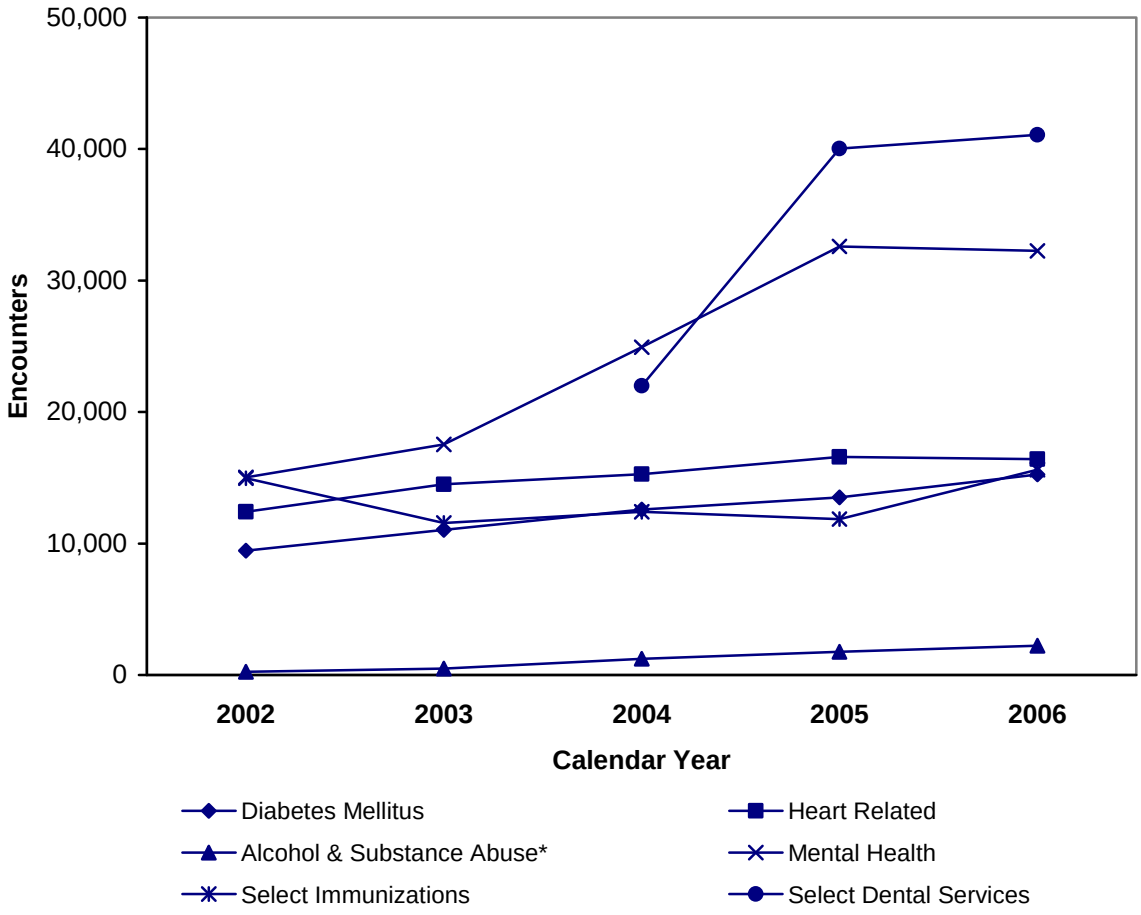
Source: UDS Universal Reports 2002-2006, provided by the Idaho Primary Care Association.

Notes: Medical expenditures refer to incurred costs. These exclude the value of donated services and supplies (value ranged from $1,971,535 in 2002 to $3,540,469 in 2005). Expenditures for substance abuse were not available separately for CY 2002. Data for CY 2006 are preliminary.

Table 16 presents information on the health expenditures incurred by CHCs in Idaho by service type during CY 2002-2006. Medical care constitutes the biggest expenditure category, over 66% during this time period. Pharmacy and pharmaceuticals and dental care are the next biggest categories of expenses incurred, representing 9-13% of accrued expenses. The relative share of pharmacy and medical care decreased during the five years by 31.5% and 2.9%, respectively. In contrast, the proportion of expenditures attributable to mental health increased by 73.3% between 2002 and 2006, yet still comprised a relatively small share (5.2%) of expenditures in 2006. Dental care expenditures also grew, from 9.7% in 2002 to 13.0% in 2006, representing an overall increase of 34.0%.

Encounters by Diagnosis Type: CHCs

Figure 35. Idaho Community Health Centers: Encounters by Select Diagnoses (CY 2002-2006)



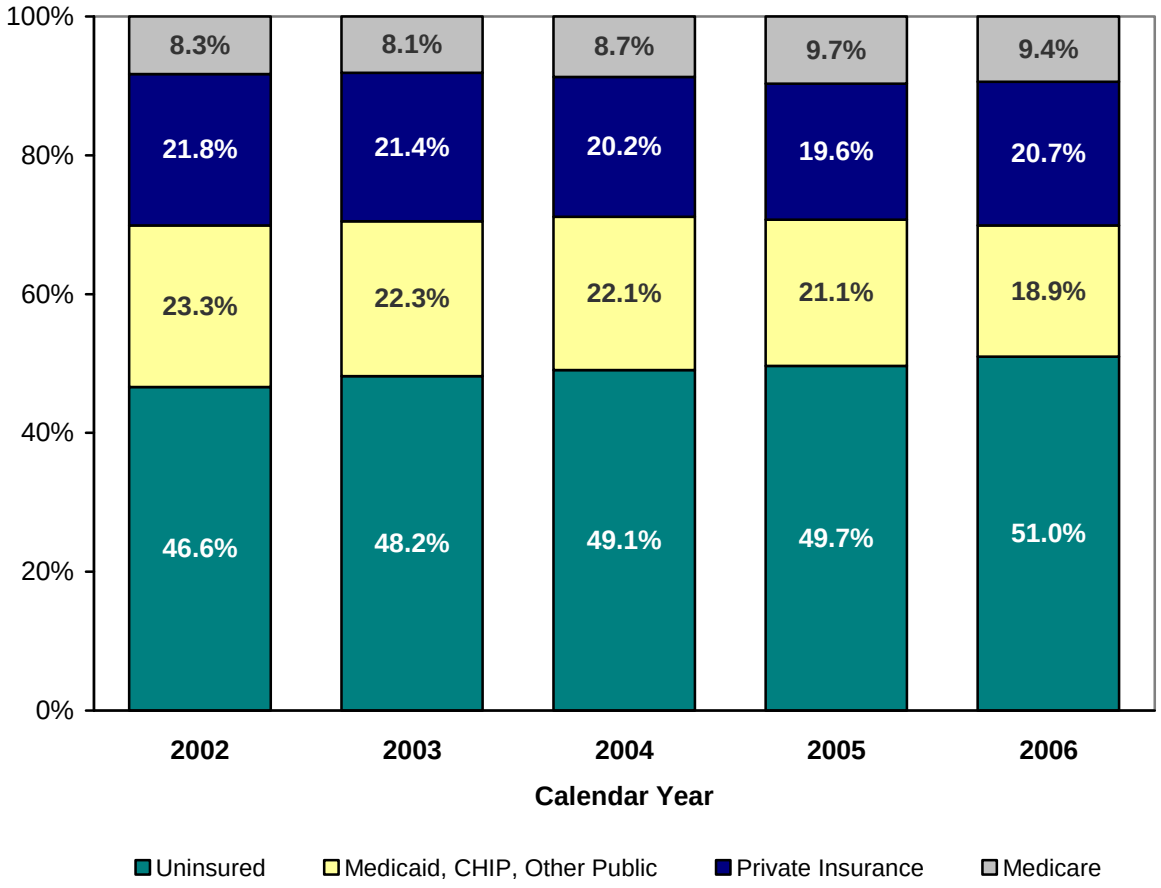
Source: UDS Universal Reports 2002-2006, provided by the Idaho Primary Care Association.

Notes: Heart-Related includes select heart diseases and hypertension; Mental Health includes depression, other mood disorders, anxiety related disorders, PTSD, attention deficit and disruptive behavior disorders, and other mental disorders. Expenditures for Dental Services are available only for CY 2004-2006. Data for CY 2006 are preliminary.

Figure 35 presents the number of encounters for select diagnoses during CYs 2002-2006. The growth in dental services (data only available for 2004-2006) also is observed here: encounters for dental care increased from 21,983 in 2004 to 41,068 in 2006 (an increase of 86.8%). Mental health encounters (e.g., depression, anxiety, other mental health disorders) also have been on the rise since 2002: these encounters doubled, from 15,046 in 2002 to 32,253 in 2006. While CHCs experienced relatively few encounters for alcohol and substance abuse, they too grew significantly over time: from 250 to 2,237 during the time frame.

Principal Source of Insurance for Users/Patients: CHCs

Figure 36. Idaho Community Health Centers: Users/Patients by Principal Insurance Source (CY 2002-2006)



Source: UDS Universal Reports 2002-2006, provided by the Idaho Primary Care Association.
Notes: Data for CY 2006 are preliminary.

Figure 36 breaks down the principal source of insurance for users/patients seen at CHCs between CYs 2002 and 2006. Not surprisingly, the uninsured made up the largest category of users (representing 45% and more) each year. The rate of uninsured users/patients grew by 9.4% from 46.6% in 2002 to 51.0% in 2006. A similar percentage of users/patients with public insurance (other than Medicare) and private insurance is observed: approximately one-fifth of CHC users/patients had either type of coverage with this percentage declining for both groups over the five years. The proportion of CHC users/patients with Medicare coverage is relatively small (9.4% in 2006) but has increased 13.3% since 2002.

Sources of Financing: CHCs

Table 17. Idaho Community Health Centers: Patient-Related Revenue by Source (CY 2002-2006)

Revenue Source	2002		2003		2004		2005		2006	
	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%
Total Public	$7,726	57.3%	$8,133	56.6%	$10,699	59.6%	$12,067	57.8%	$12,340	55.0%
Medicaid	$6,264	46.5%	$6,700	46.6%	$8,734	48.6%	$9,186	44.0%	$9,389	41.8%
Medicare	$1,341	9.9%	$1,286	8.9%	$1,821	10.1%	$2,759	13.2%	$2,864	12.8%
Other Public	$121	0.9%	$147	1.0%	$144	0.8%	$122	0.6%	$86	0.4%
Total Private	$5,754	42.7%	$6,244	43.4%	$7,264	40.4%	$8,793	42.2%	$10,097	45.0%
Private Managed/Non-Managed Care	$2,766	20.5%	$3,100	21.6%	$3,321	18.5%	$4,103	19.7%	$4,779	21.3%
Self-Pay	$2,988	22.2%	$3,144	21.9%	$3,943	22.0%	$4,691	22.5%	$5,318	23.7%
Total Patient-Related Revenue	$13,480	100.0%	$14,377	100.0%	$17,962	100.0%	$20,861	100.0%	$22,437	100.0%

Source: UDS Universal Reports 2002-2006, provided by the Idaho Primary Care Association.

Notes: Patient-related revenue is reported on the basis of the amount collected during the year. Private Managed/Non-Managed Care refers to private capitated and fee-for-service health plans. Data for CY 2006 are preliminary.

Funding for CHCs comes from two distinct mechanisms—revenues from patient-related services and non-patient related revenue which refers to public grant funds or contracts. Details on both are presented in Tables 17 and 18. At least 55% of the revenues generated by services rendered to patients come from public programs, with Medicaid being the largest contributor followed by Medicare. The balance of the patient-related revenue (40.0-45.0%) comes from users who self pay or have private insurance coverage. While revenue amounts from both public and private sources increased between 2002 and 2006, the share of patient-related revenue from public sources declined slightly by 4.0%, whereas the contribution of private sources increased modestly by 5.4%. The relative decrease in public revenue is mostly attributable to Medicaid (Medicaid's share of patient funding dropped by 10.1%); the increase in private contributions is related to increases in both private insurance and self pay – especially the latter, the share of which grew by 6.8%.

Table 18. Idaho Community Health Centers: Non-Patient-Related Revenue by Source (CY 2002-2006)

Revenue Source	2002		2003		2004		2005		2006	
	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%	$ (thousands)	%
Total Public	$11,718	97.1%	$11,962	96.7%	$15,016	97.7%	$17,608	94.3%	$19,756	94.9%
Federal	$11,307	93.7%	$11,560	93.5%	$14,417	93.8%	$17,179	92.0%	$19,131	91.9%
State	$317	2.6%	$250	2.0%	$391	2.5%	$283	1.5%	$474	2.3%
Local	$94	0.8%	$152	1.2%	$208	1.4%	$147	0.8%	$152	0.7%
Total Private	$354	2.9%	$404	3.3%	$356	2.3%	$1,068	5.7%	$1,067	5.1%
Foundation/Private	$298	2.5%	$328	2.6%	$356	2.3%	$586	3.1%	$610	2.9%
Other Revenue	$56	0.5%	$77	0.6%	$0	0.0%	$482	2.6%	$457	2.2%
Total Non-Patient Related Revenue	$12,072	100.0%	$12,366	100.0%	$15,372	100.0%	$18,676	100.0%	$20,823	100.0%

Source: UDS Universal Reports 2002-2006, provided by the Idaho Primary Care Association.

Notes: Federal includes BPHC grants, other federal grants, Indian Health Service monies; State & Local include government grants and contracts; Foundation/Private includes grants and contracts. For CY 2004, Other Revenue reported in the amount of $2,126,648 is assumed to be IHS monies, and classified as Federal Revenues. Data for CY2006 are preliminary.

In terms of non-patient related revenue, public grants and contracts make up well over 90% of CHC funding (see Table 18). These public grants are largely federal dollars (including grants from the Bureau of Primary Health Care (BPHC) and the Indian Health Services (IHS)). In fact, in 2006, state and local grants and contracts comprised only 3.0% of the total non-patient related revenue received by CHCs. Private and foundation funding and other private revenue make up less approximately 5% of CHC non-patient related finances.

Highlights - CHCs

- Between 2002 and 2006, Idaho's CHCs experienced a jump in users/patients served and especially in expenditures. The number of individuals served increased by 43.1% to over 92,000; overall expenditures grew by 71.4% to $43.0 million.
- During the five year time span, administrative expenses grew by about 79.7% between 2002 and 2006 and represented just under a third of total accrued costs in 2006.
- The uninsured made up the largest category of users (representing just over half in 2006). The rate of uninsured users/patients grew by 9.4% between 2002 and 2006. The proportion of CHC users/patients with Medicare coverage was relatively small (9.4% in 2006) but also increased 13.3% after 2002. CHC users/patients with Medicaid or private insurance decreased during the five-year time period.
- Public programs funded over a half of the CHCs' patient-related revenue, with Medicaid being the largest contributor. Nonetheless, while revenue amounts from both public and private sources increased between 2002 and 2006, the share of patient-related revenue from public sources declined slightly by 4.0%, whereas the contribution of private sources (i.e., private insurance, self-pay) increased modestly by 5.4%.
- Public grants and contracts (especially federal) funded the overwhelming majority (95%) of the CHCs' non-patient-related revenue. Private and foundation funding and other private revenue make up the balance of CHCs' non-patient related finances.

OTHER PROGRAMS:
ADULT CORRECTIONS HEALTH CARE

ADULT CORRECTIONS HEALTH CARE

Program Description

The Idaho Department of Correction is the state agency responsible for processing and housing the state's adult prison population. (The State Department of Juvenile Corrections, discussed next, oversees the placement of juvenile offenders.) Adult inmates are housed in four residential contexts: prison institutions owned and operated by the state, the Idaho Correctional Center (a state-owned but privately-operated facility), Idaho county jails, and facilities located in other states. Currently, there are seven state prisons. Out-of-state inmate placements are relatively rare. DOC currently has arrangements with three facilities in Texas and one in Oklahoma.

The state incurs costs for medical care required by all DOC inmates regardless of their placement location. For the state's institutionalized inmate population, medical services are provided via a state contractor. Among the five years of interest to this project, Prison Health Services (PHS) held this contract during FYs 2002 through 2005. Correctional Medical Services (CMS) has had the medical services contract since FY 2006. Corrections Corporation of America (CCA) operates the Idaho Correctional Center (ICC), and medical expenses also are incorporated into the state's overall contract with this provider. Likewise, the GEO Group is the main contractor for Idaho's inmates placed in out-of-state facilities. Medical expenses also are incorporated into this contract. GEO Group in turn subcontracts with Physicians Network Association (PNA) for the medical services required by these inmates. For DOC inmates placed in county jails, the state reimburses counties for medical expenses incurred.

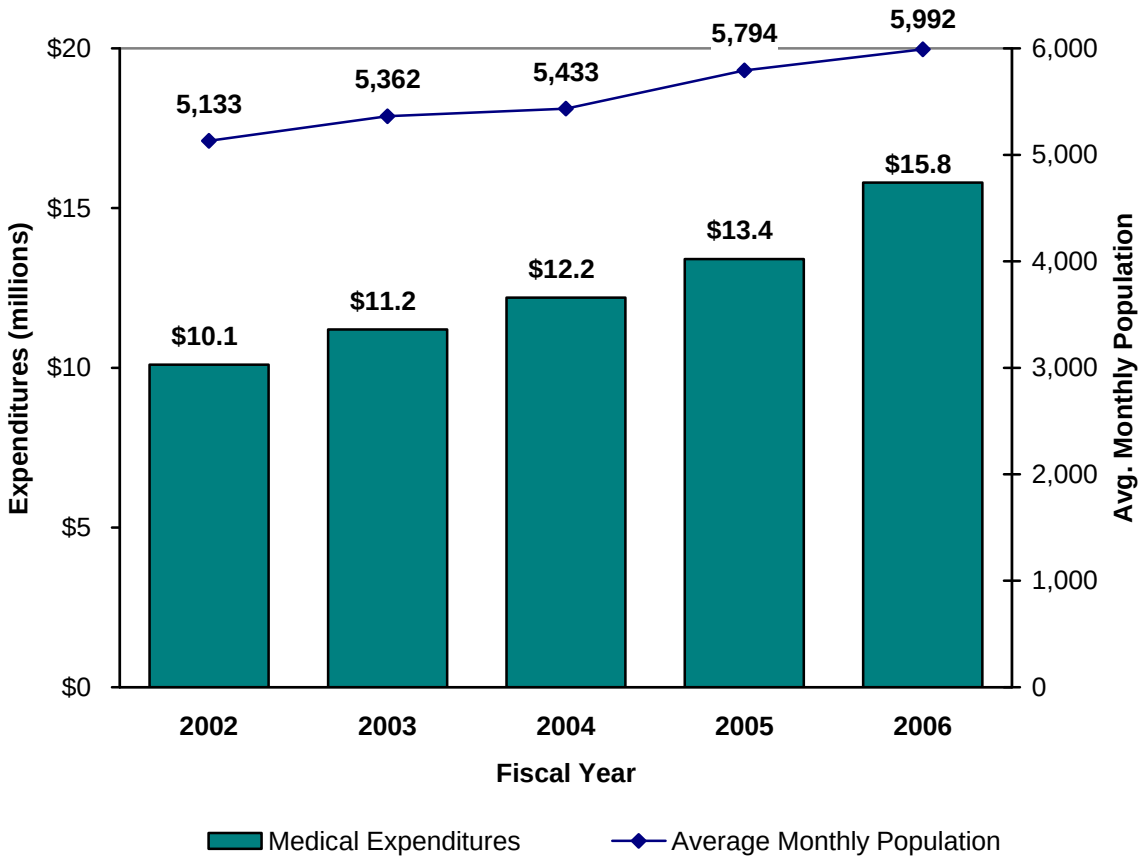
Data Sources

The majority of data regarding medical expenses for the state's adult correction population was obtained directly from the DOC. Attempts also were made to contact the contractors responsible for the medical services provided to each of the four types of inmates described above. Detailed information on administrative and medical spending by service type and diagnosis type were mostly unavailable. Contractors are not required to report this information to DOC, and some of the contractors had concerns about sharing information that could be considered proprietary in nature. In this report, we present both prison population numbers and overall expenditures on medical services/contracts. Population data were available from DOC for all four placement contexts. Expenditure information was available for state inmates housed in prison institutions owned and operated by the state, Idaho county jails, and facilities located in other states but not the ICC. Consequently, the expenditures reported here underestimate actual adult corrections medical expenditures.

Findings

Prison Population Size and Medical Expenditures: Adult Corrections

Figure 37. Idaho's Department of Correction: Medical Expenditures and Prison Population Size (FY 2002-2006)



Source: All enrollment data are from the Idaho Department of Correction (DOC). DOC also provided medical expenditure data for state institution and county jail inmates. PNA provided expenditure information for out-of-state inmates.

Notes: Population counts include state DOC adult prisoners who are located in Idaho's state institutions, the Idaho Correctional Center (ICC, privately-operated facility), out-of-state prisons, and county jails. Expenditures exclude ICC medical costs (which were not available). Expenditures include administrative costs associated with medical services for prisoners housed within Idaho's state institutions, out-of-state prisons, and county jails. Data do not pertain to community work centers or contract beds outside of Texas.

Figure 37 summarizes Idaho's adult inmate population size and affiliated medical expenditures for FYs 2002-2006. Idaho's adult inmate population increased 16.7% during the five-year time period, from a monthly population of 5,133 to 5,992. Likewise, since FY 2002, medical expenditures for this population increased steadily, growing by about 56.3% by FY 2006, when they amounted to $15.8 million. Because ICC medical expenses could not be included, these expenditures underestimate total adult correction medical spending during these years.

Highlights – Adult Corrections

- Between FY 2002 to 2006, Idaho's adult inmate population grew by 16.7% to almost 6,000 inmates. Affiliated medical expenditures increased disproportionately: from $10.1 million in FY 2002 to $15.8 million in FY 2006, representing an overall 56.4% growth in spending. Because ICC medical expenses could not be included, these expenditures underestimate total adult correction medical spending during these years.

OTHER PROGRAMS:
JUVENILE CORRECTIONS HEALTH CARE

JUVENILE CORRECTIONS HEALTH CARE

Program Description

Currently, the Idaho Department of Juvenile Corrections (DJC) runs three correctional facilities—Lewiston, Nampa, and St. Anthony. In addition to these facilities, juveniles[21] also are placed with contracted providers, including private and county-owned facilities. DJC provides health and counseling services to its incarcerated juveniles. Each of the three facilities is staffed by Registered Nurses (RNs) and Licensed Practical Nurses (LPNs).[22] Table 19 below presents information on these facilities in terms of capacity, target population and services available.

Table 19. Idaho's Juvenile Correctional Facilities: Summary Information

Facility	Capacity[22]	Target Populations	Select Services Available
Lewiston	36 beds	• Medium-high risk adjudicated male juvenile offenders aged 13-18 years; • Focused on juveniles from Idaho's 10 northern counties; • Juveniles with significant substance abuse issues	• Assessments • On-site 24-hr. on-call nurse • Medical/dental/vision • Counseling services (drug and alcohol)
Nampa	60 beds	Not available	• Initial physical/mental screening • Off-site medical/dental/optical emergency care • Clinical assessments
St. Anthony	148 beds	• High-risk adjudicated male and female juvenile offenders aged 13 -19 years	• On-site, full-time nurses/physician assistant • Medical/dental/vision • Counseling services (individual/family/ drug and alcohol)

Source: Idaho Department of Juvenile Corrections website.

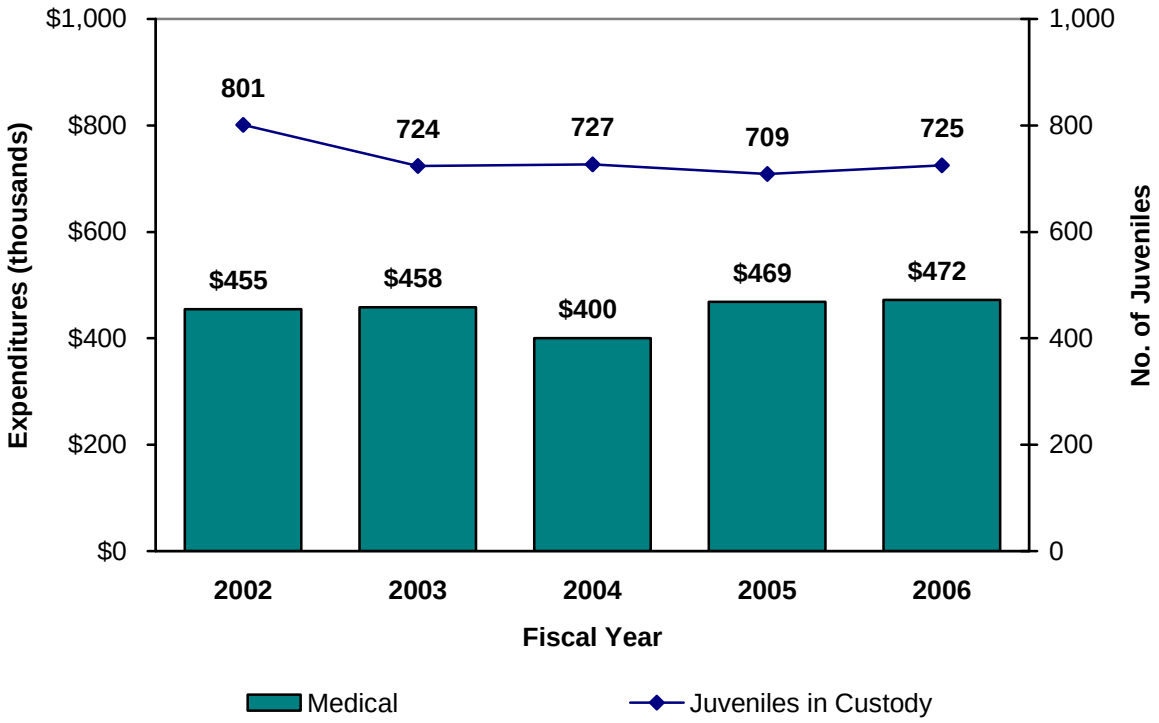
Data Sources

Data on health expenditures for incarcerated juveniles were provided to SHADAC by DJC. The data include medical expenditures by facility (including payments to contract providers) and by service type for FYs 2002-2006. The main categories DJC uses to document medical expenses include: pharmacy, off-campus costs (including services provided by doctors and hospitals as well as medical consultations), dental, optical, clinical assessments, and counseling. Spending for mental health and substance abuse services could not be isolated but are captured in several of the categories above.

Findings

Juveniles Served and Medical Expenditures: Juvenile Corrections

Figure 38. Idaho Juvenile Corrections Health Care: Medical Expenditures and Juveniles Served (FY 2002-2006)



Source: Data provided by the Idaho Department of Juvenile Corrections.
Notes: Administration expenditures are not available. Data are for all juvenile institutions and contract providers.

Figure 38 presents the number of juveniles incarcerated by DJC between FY 2002 and 2006 as well as the total medical expenditures incurred by the Department. The total number of juveniles in custody fluctuated between FYs 2002-2006 but, overall, decreased by 9.5% to 725 juveniles during the five-year time span. In contrast, medical expenditures grew from $454,516 in FY 2002 to $472,285 in FY 2006 for a relatively modest increase of about 3.9%.

Medical Expenditures by Service Type: Juvenile Corrections

Table 20. Idaho Juvenile Corrections Health Care: Medical Expenditures by Service Type (FY 2002-2006)

	2002		2003		2004		2005		2006	
Service Type	$	%	$	%	$	%	$	%	$	%
Pharmacy	$202,438	44.5%	$243,335	53.1%	$184,659	46.1%	$218,096	46.5%	$209,529	44.4%
Off Campus	$120,350	26.5%	$118,475	25.8%	$96,692	24.2%	$100,860	21.5%	$157,335	33.3%
Counseling	$50,261	11.1%	$29,769	6.5%	$42,333	10.6%	$51,690	11.0%	$13,141	2.8%
Dental	$41,726	9.2%	$39,144	8.5%	$54,825	13.7%	$69,711	14.9%	$71,610	15.2%
Assessments	$22,635	5.0%	$7,950	1.7%	$3,650	0.9%	$2,420	0.5%	$760	0.2%
Optical	$17,105	3.8%	$19,695	4.3%	$18,217	4.5%	$25,970	5.5%	$19,910	4.2%
Total	$454,516	100.0%	$458,368	100.0%	$400,376	100.0%	$468,747	100.0%	$472,285	100.0%

Source: Data provided by the Idaho Department of Juvenile Corrections.

Notes: Off-campus includes services provided by doctors and hospitals as well as medical consultations. Mental health/substance abuse-related expenses are captured in multiple service types. Data are for all juvenile institutions and contract providers.

Table 20 presents information on medical expenditures by service type for all of the three facilities as well as payments made to contract providers for the five FYs, 2002-2006. Pharmacy expenditures have consistently been the budget driver across all years (representing at least 44.0% in all years and as high as 53.1% in FY 2004). Services provided by doctors and hospitals or medical consultations (i.e., off-campus costs) also contributed a fair share (21.5% and more) to the health care expenditures incurred by DJC.

Pharmacy and optical expenditures stayed relatively stable over time in terms of their role in DJC's overall medical bill. In contrast, dental expenditures grew considerably during the five years (from $41,726 to $71,610, or by 71.6%), and off-campus expenditures grew to $157,335, a relative increase of 30.7% since FY 2002. Additionally, over time, expenditures for assessments decreased by 96.6% (from $22,635 to $760) and as of FY 2006, counseling-related expenditures dropped by 73.6% to $13,141.

Highlights – Juvenile Corrections

- Between FYs 2002 and 2006, the total number of juveniles in DJC custody decreased by 9.5% to about 725 juveniles. Medical expenditures for this population grew slightly during the same time period (3.9%) to $472,285 in FY 2006.
- Prescription drugs, hospital/doctor services, and medical consultations combined have consistently representing the largest share (between 68.0% and 78.9%) of overall DJC medical expenditures each year.
- The largest increases in expenditures were observed for the hospital/doctor/medical consultation and dental service categories. In contrast, noteworthy decreases were seen for assessments and counseling.

OTHER PROGRAMS:
COUNTY CORRECTIONS HEALTH CARE

COUNTY CORRECTIONS HEALTH CARE

Program Description

Under Idaho Code §20-601, county sheriffs maintain jails used to detain persons committed to guarantee their attendance as witnesses in criminal cases; detain persons charged with a crime and directed to trial; confine those convicted of and sentenced for a crime; confine persons otherwise committed; and hold any arrested person taken to jail who refuses the booking process.[23] County jail inmates may include state prisoners who are temporarily placed in county jails or serving their sentence there (see related information under Adult Correction). Typically, county jails are designed to house individuals awaiting trial or serving a short sentence (i.e., less than a year). Inmates therefore tend to be in jail for short durations of time.

To respond to inmates' medical needs while in jail, sheriffs may require inmates to provide information related to health insurance and determine whether inmates qualify for local, state or federal programs. County sheriffs may direct medical expenses to an inmate's health insurance carrier. If an inmate is deemed non-indigent (defined as an inmate who "has money in his commissary or personal account" [24]), s/he may be charged and billed the costs of any medical care provided. Jails may collect inmate debts from non-indigent inmates for up to four years from the date of incarceration. [25] Medical care expenditures for the indigent inmates are provided for by the county, often covered under the county medical indigency program, the state Catastrophic Program (if costs exceed $10,000 in a twelve month period), or other programs such as Medicaid. Health care expenses incurred by counties for state prisoners are reimbursed by the state DOC.

Data Sources

No centralized database on county jail medical expenditures currently exists for the entire state. For the purposes of this study, we estimate total medical expenditures for Idaho's county jail inmate population based on data for one county, Ada County (Boise). Keeping in mind the experience of the county medical indigency program, we used this approach (instead of primary data collection from individual counties) due to concerns about the quality and timeliness of data from some counties. We selected Ada County for our estimation purposes because Ada County constitutes the largest share (at least 20% in 2005 and 2006) of the state's total jail population. Ada County, the largest and most urban county in the state, also has an established data system, and jail medical expenditure data are readily available. Although Ada County represents a significant proportion of the state's overall county jail population, estimates based on only one county should be interpreted with caution. For example, it is possible that the extent of medical expenses observed for Ada County (and any changes thereto) may not be representative of all county jails in the state.

To estimate Idaho's county jail inmate medical expenditures, we obtained county-level information on the state's jail population and medical spending specifically for Ada County. For each county with a jail, the Idaho Sheriffs' Association provided the number of prisoner days per month for CYs 2005 and 2006. Ada County Sheriff's Office furnished medical care expenditures for CFYs 2002- 2006. To estimate total medical expenditures for all Idaho county jail inmates, we calculated the cost per prisoner day for Ada County (calculated from the total

number of prisoner days and the total annual medical costs for Ada County) applied this rate to the total prisoner days in the state for each year. Ada County also provided expenditure information for administration and by general health care service categories (medical vs. dental). Data for detailed service categories or diagnoses were unavailable.

Findings

Inmate Population Size: County Corrections

Table 21. Idaho's County Jails: Share of Total Jail Prisoner Days by County (CY 2005-2006)

County	2005	2006
Ada	24.4%	20.1%
Canyon	18.9%	17.6%
Kootenai	8.1%	9.1%
Bonneville	8.0%	7.4%
Bannock	7.0%	6.7%
Remaining Counties with 1-6% of Prisoner Days	22.9%	29.7%
Remaining Counties with <1% of Prisoner Days	10.7%	9.4%
Total	100.0%	100.0%

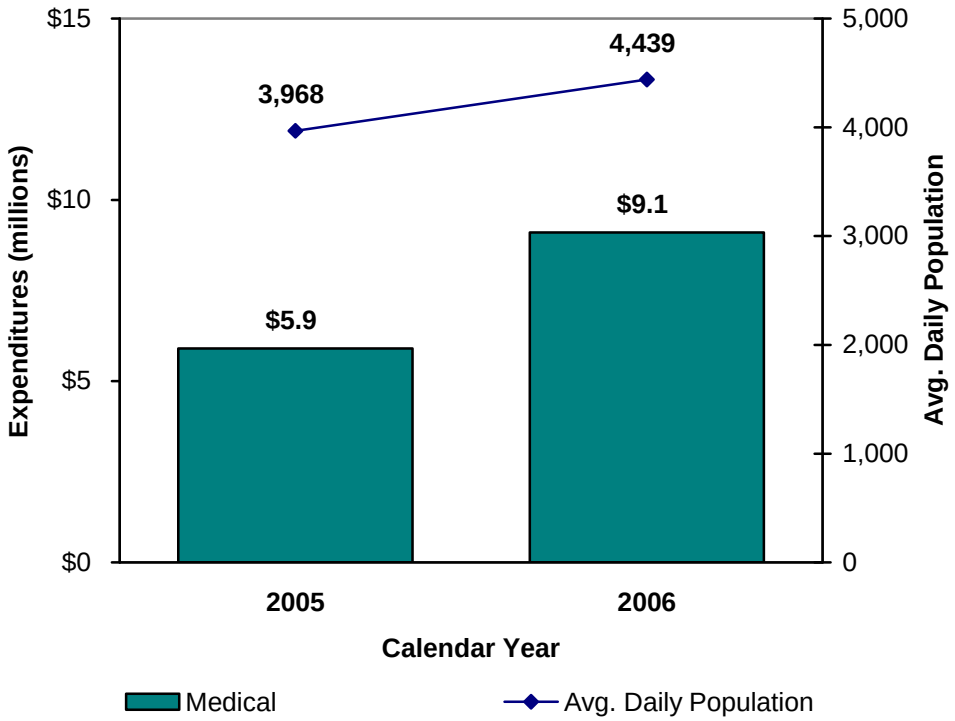
Source: Idaho Sheriffs' Association.

Notes: Data for three counties were incomplete and estimated by SHADAC based on other available data for these counties.

Table 21 summarizes the distribution of Idaho's county jail population (expressed in jail prisoner days) for CYs 2005 and 2006. Data are shown for individual counties with more than 6.0% share of the total population; counties with less than 6.0% of the population are grouped together. In both of these years, Ada County constituted 20.0% or more of the state's total jail population.

Medical Expenditures: County Corrections

Figure 39. Idaho's County Jails: Estimated Total Medical Expenditures and Inmate Population Size (CY 2005-2006)



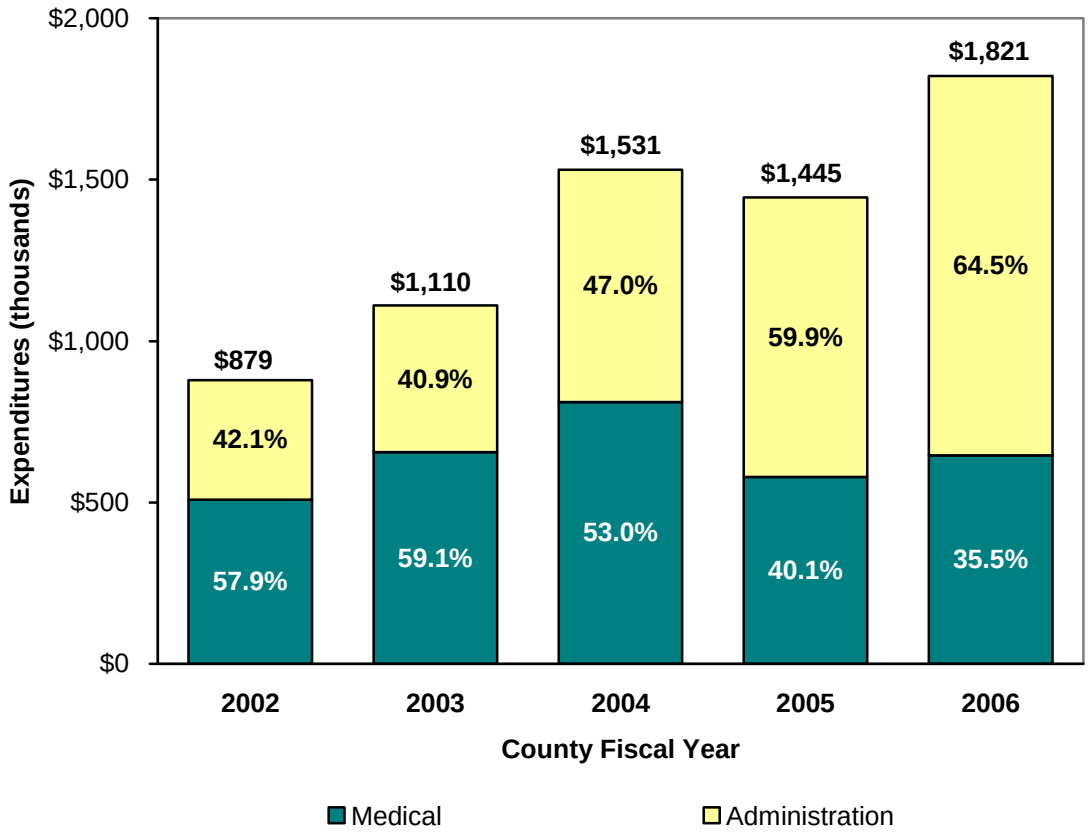
Source: Total prisoner days per month for Idaho were provided by the Idaho Sheriffs' Association. Medical expenditures were provided by the Ada County Sheriff's Office.

Notes: Monthly inmate population size was derived from total prisoner day counts available for CYs 2005 and 2006. Total county jail medical expenditures were estimated for this population based on medical costs incurred by Ada County during CFYs 2005 and 2006.

Figure 39 presents Idaho's total county jail population (expressed as an average daily inmate population) along with the estimated medical expenditures for this population during CYs 2005 and 2006. As described above, the expenditure estimates are based on per-prisoner day medical expenditures for Ada County. We estimate that, between the two years, Idaho's total county jail medical spending increased from $5.9 to $9.1 million, for a relative increase of 53.0%. During the same period, Idaho's jail population grew by 11.9%, to 4,439 inmates in CY 2006.

Medical vs. Administrative Expenditures: Ada County Jail

Figure 40: Ada County Jail: Medical-Related Expenditures by Category (CFY 2002-2006)



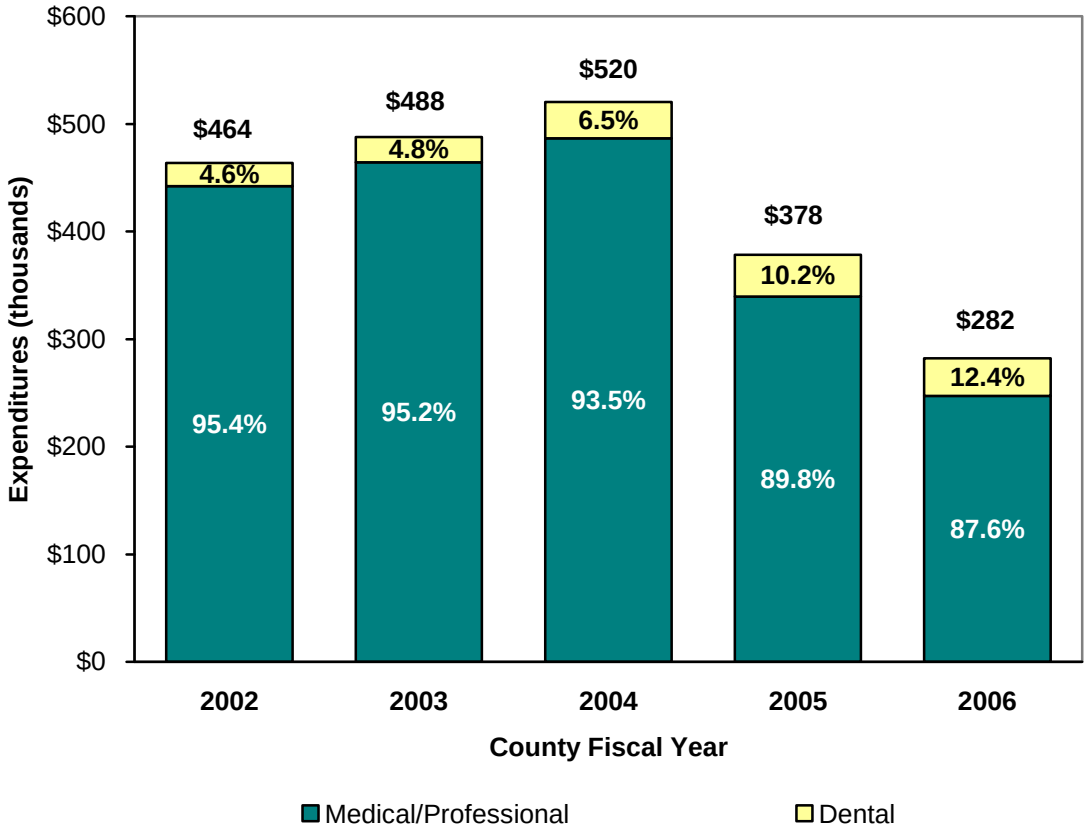
Source: Ada County Sheriff's Office.
Notes: Medical expenditures include both contracted and outside provider services and also include services provided to indigents which may be covered under the Idaho County Medical Indigency Program/State Catastrophic Program. Administration includes supplies/equipment, jail medical staff salary/benefits, malpractice insurance, etc.

Figure 40 presents details on Ada County jail's medical-related expenditures for CFYs 2002-2006, by expenditure category. Expenditures for contracted and outside provider health care services were highest in CFY 2004, when they amounted to $810,884, or 53.0% of the jail's total medical-related expenditures. Since then, these medical expenses have decreased and represented smaller proportions of overall spending (40.1% in CFY 2005, 35.5% in CFY 2006).

Administration expenditures associated with medical care increased fairly consistently for Ada County during the five years. In CFY 2002, these expenditures amounted to $369,854 (or 42.1%) of total medical-related expenditures; in CFY 2006, they totaled $1,175,003, up to 64.5% of total medical-related expenditures. The decrease in contractor/outside provider medical expenditures and the increase in administrative expenditures are attributed to several changes, including management decisions to use fewer contracted services and to hire more internal staff as well as more recent payments towards malpractice insurance.[26]

Medical Expenditures by Service Type: Ada County Jail

Figure 41: Ada County Jail: Contracted Medical Expenditures by Service Type (CFY 2002-2006)



Source: Ada County Sheriff's Office.
Notes: Data are for contracted services only. Do not include services provided by outside providers, nor jail medical staff.

Figure 41 presents information on Ada County Jail's contracted medical expenditures by two broad service categories (medical vs. dental costs) for CFYs 2002-2006. (Data are for contracted services only and do not pertain to services provided by outside providers or jail medical staff.)

Overall, contracted service expenditures have decreased since CFY 2004, totaling $281,997 in CFY 2006. The proportion of these expenditures dedicated to medical services dropped from 95.4% (CFY 2002) to 87.6% (CFY 2006). In contrast, the proportion of dental expenditures increased over the five-year period, comprising $35,019 or 12.4% of total contract expenditures in CFY 2006.

Highlights – County Corrections

- Idaho's county jail inmate population increased by 11.9% between CYs 2005 to 2006 (to an average daily population of 4,439), while estimated medical expenditures for this population (based on Ada County medical expenditures) increased from $5.9 million to $9.1 million, a relative increase of 53.0%.

- For Ada County Jail, expenditures for contracted and outside provider health care services has decreased over time, where as administrative expenses have grown fairly consistently. The increase in administrative expenditures is attributed to several changes including management decisions to use fewer contracted services and to hire more internal staff as well as more recent payments towards malpractice insurance.
- Since CFY 2002, the proportion of Ada County Jail's contracted medical services attributable to dental care has grown, representing of 12.4% these expenditures in CFY 2006.

OTHER PROGRAMS:
PUBLIC HEALTH SERVICES

PUBLIC HEALTH SERVICES

Program Description

The state of Idaho directs resources to public health services including health promotion, disease prevention and emergency medical services through two of its Health and Human Services components: Department of Health and Welfare (DHW) and regional public health districts. Based on DHW's current organization, two divisions are primarily responsible for providing and/or sponsoring such services using federal and state funds. The two divisions are: Division of Public Health (including physical health and emergency medical services) and Division of Behavioral Health (adult and children's mental health services, substance abuse services, and psychiatric hospitalization). Table 22 summarizes the activities and programs funded.

Table 22. Summary of Idaho's DHW Public Health Services

Division and Function	Programs and Activities
Public Health	
Physical Health Services	DHW administration
	Health administration (Offices of Epidemiology and Rural Health)
	Bureau of Community & Environmental Health (health promotion and education, environmental health)
	Governor's Council (adolescent pregnancy prevention)
	Preventive services (cancer, HIV, STD, and other disease prevention; immunizations; reproductive and newborn health; WIC)
	Vital statistics and health preparedness (health statistics, surveillance, public health preparedness, vital records)
Emergency Medical Services	Statewide response system for emergency illnesses and injuries
Behavioral Health	
Substance Abuse Services	Administration (e.g., central and regional administration)
	Access to Recovery program (e.g., adolescent and adult recovery treatment services)
	Drug courts (adolescent, adult, and mental health courts)
	Prevention (e.g., regional allocations for prevention activities, media campaigns)
	Treatment (e.g., contracts with private providers to provide adolescent and adult treatment)
	Youth Tobacco program (e.g., tobacco inspections, research on outcome measures)
	Mental Health Bureau (staff activities and administration costs)
Adult Mental Health Services	Base program services (e.g., consumer and family support and advocacy; facility maintenance and improvements; mental health planning council (oversight body in state); and data collection and infrastructure projects)
	Housing services for adults with serious mental illness
	Sheltered Workshops (work training for adults with serious mental illness)
	Assertive Community Treatment program (intensive community services for adults with mental illness; includes case and medication management, rehab, therapy)

Division and Function	Programs and Activities
	Projects for Assistance in Transition from Homelessness (PATH: services to adults with serious mental illness who are homeless or at risk of homelessness)
	Support for regional adult mental health programs
	Audits and training for Medicaid psychosocial rehabilitation services
Children's Mental Health (CMH) Services	DHW administration
	Child clinical receipts (e.g., therapy and counseling through contracts with providers or Medicaid)
	Family clinical services (contracts for services)
	Children's Mental Health Initiative (e.g., training of community members and evaluation to improve services for children and families with serious emotional disorders)
	Information technology (e.g., reports and data tracking regarding CMH)
	Block Grant special projects (e.g., family advocacy, activities)
	Foster care (mental health services for children placed outside of home by parents)
	Idaho and regional councils on children's mental health (oversight of services in state; provider guidance, training, consultation, and collaboration)
	Professional training (training on children's mental health to communities at large and public/private providers)
Community Hospitalization	Temporary residential care for individuals who are on a waiting list for a state hospital bed
State Hospitals	Short and long-term residential care and treatment for whom community living is considered unsafe. There are two state hospitals (North and South).

Source: Department of Health and Welfare and the 2008 Idaho Legislative Budget Book.
Notes: Physical health also includes laboratory services, which have been excluded for the purposes of this report.

Under DHW's Public Health Division, the department directs monies to the state's seven public health districts, which are "primary outlets for public health services" in the state (IDHW website). These districts provide community health and home health nursing, dental health, and nutrition services. The purpose of this DHW funding is to support the physical health preventive services that the districts provide.

The public health districts, which are autonomous, multi-county agencies, also receive other state funding (through general fund appropriations) as well as county-level funding and reimbursements through receipts. For the purposes of this report, we present information on DHW public health service expenditures (including contracts with the public health districts) as well as the state's direct general fund appropriations for the seven districts.

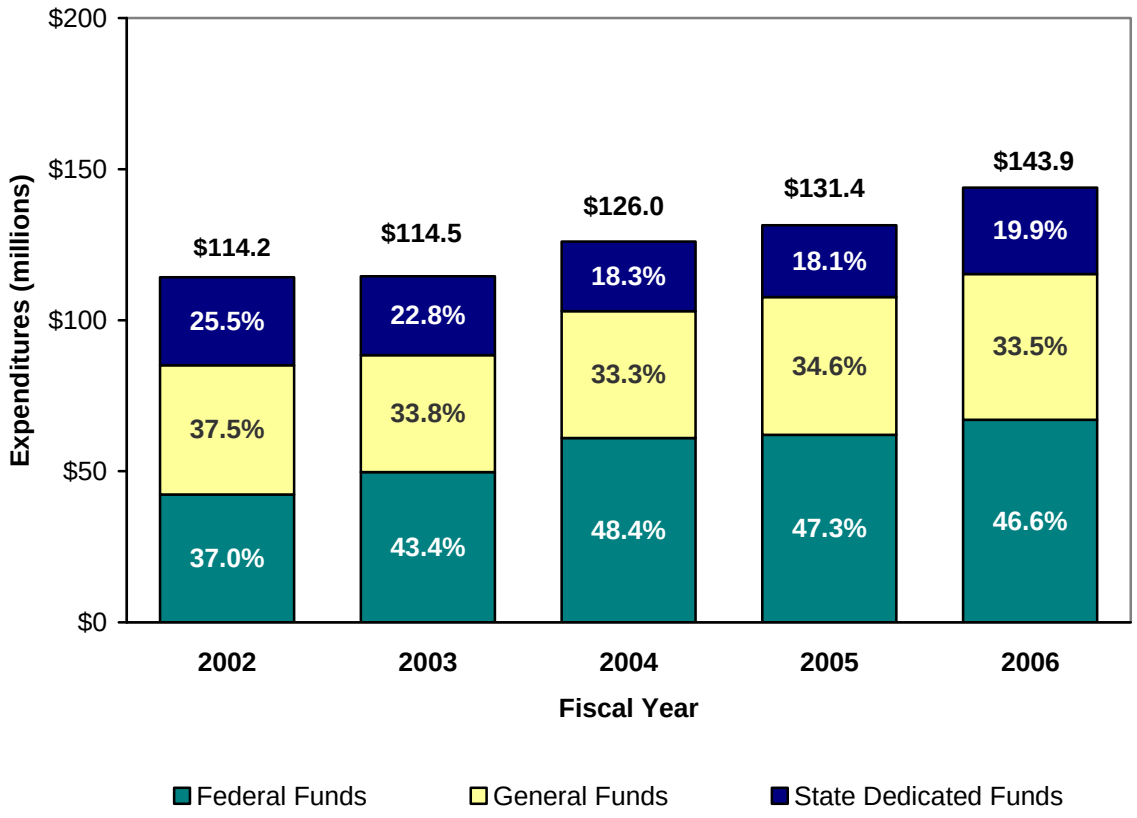
Data Sources

Data on public health service expenditures were obtained from two sources. All data presented in this report concerning DHW public health service areas came from the Department's Division of Management Services. The Legislative Services Office (LSO) provided data on separate state appropriations and expenditures for the public health care districts.

Findings

Public Health Expenditures by Funding Source: DHW and Public Health Districts

Figure 42. Idaho's Public Health Services: Expenditures by Funding Source (FY 2002-2006)



Source: Idaho Department of Health and Welfare and Idaho Legislative Services Office.

Notes: Public health services include expenses by the Department of Health and Welfare for physical health, emergency medical services, substance abuse, adult mental health, community hospitalization, state hospital north, and state hospital south. Direct state/federal appropriations to public health districts in the state also are included. However, county expenditures/funding for public health districts are excluded. Children's mental health is excluded from this exhibit because its funding breakdown was not available for all years.

Figure 42 above presents total public health expenditures (for DHW and public health districts) by source of funding (federal, state general fund, and state dedicated funds) for FYs 2002-2006. During this time frame, expenditures grew by 26.0% from $114.2 million in FY 2002 to $143.9 million in FY 2006. Since FY 2003, state general funds have consistently supported about a third of these public health expenses. The share of expenses supported by federal and state dedicated funds fluctuated somewhat during the five years, with federal funds representing the largest share (at least 43.4%) since FY 2003 and state dedicated funds covering the remainder (19.9% in FY 2006).

Table 23. Idaho's Public Health Services: Expenditures by Function and Funding Source (FY 2002-2006)

Function	2002 (millions)	2003 (millions)	2004 (millions)	2005 (millions)	2006 (millions)
Public Health Districts					
Total Expenditures	$10.6	$10.0	$9.7	$9.9	$10.4
State	$10.6	$10.0	$9.7	$9.9	$10.4
Federal	$0.0	$0.0	$0.0	$0.0	$0.0
Department of Health and Welfare					
Physical Health					
Total Expenditures	$46.2	$49.3	$57.8	$60.9	$61.4
State	$14.4	$14.6	$15.1	$16.0	$17.3
Federal	$31.8	$34.8	$42.7	$44.9	$44.1
Emergency Medical Services					
Total Expenditures	$3.6	$3.6	$3.9	$5.0	$5.5
State	$3.0	$2.8	$3.3	$3.5	$4.3
Federal	$0.6	$0.8	$0.6	$1.5	$1.3
Substance Abuse					
Total Expenditures	$11.9	$12.9	$14.1	$13.5	$18.3
State	$5.7	$4.7	$5.3	$5.7	$4.5
Federal	$6.2	$8.2	$8.8	$7.8	$13.8
Children's Mental Health					
Total Expenditures	$12.0	$12.0	$14.7	$15.6	$18.8
State	--	--	--	--	$12.9
Federal	--	--	--	--	$5.9
Adult Mental Health					
Total Expenditures	$18.6	$16.4	$17.9	$18.6	$18.9
State	$14.9	$12.6	$13.9	$14.3	$15.0
Federal	$3.7	$3.8	$4.0	$4.2	$3.9
Psychiatric Hospitalization					
Total Expenditures	$23.3	$22.3	$22.6	$23.5	$29.4
State	$23.3	$20.2	$17.7	$19.8	$25.4
Federal	$0.0	$2.1	$4.9	$3.7	$4.0

Source: Idaho Department of Health and Welfare and Idaho Legislative Services Office.

Notes: Public health services include expenses by the Department of Health and Welfare for physical health, emergency medical services, substance abuse, and adult and children's mental health. Direct state/federal appropriations to public health districts in the state also are included; however, county expenditures and funding are not. Children's mental health expenditures by source of funding are only available for FY 2006. Psychiatric Hospitalization includes community hospitalization and both North and South State Hospitals.

Table 23 presents funding source trends at a lower level – for public health districts and for each of the main public health functions within DHW's Divisions of Public Health and Behavioral Health. Between FYs 2002 and 2006, direct state appropriations for regional public health districts held consistently at approximately $10 million per year. Within DHW, expenditures increased noticeably across all areas between FYs 2002 and 2006, with the exception of adult mental health services, which in both FYs 2002 and 2006 were at approximately $19 million. State funding grew between FYs 2002 and 2006 for all DHW public health service areas, especially for physical health services (from $14.4 to $17.3 million, or 19.8%). Federal funding also increased over the years (except for adult mental health) and grew particularly for physical health services (from $31.8 to $44.1 million, or 39%) and substance abuse services (from $6.2 to $13.8 million, or 122.6%).

Public Health Expenditures by Function and Activity: DHW

Table 24. Idaho's Department of Health and Welfare: Physical Health Expenditures by Activity (FY 2002-2006)

Activity	2002 (millions)	2002 %	2003 (millions)	2003 %	2004 (millions)	2004 %	2005 (millions)	2005 %	2006 (millions)	2006 %
Preventive Services	$36.0	77.9%	$36.6	74.2%	$41.6	72.0%	$41.2	67.7%	$41.9	68.2%
Vital Statistics/Health Preparedness	$4.0	8.7%	$6.2	12.6%	$8.7	15.1%	$11.6	19.0%	$10.5	17.1%
Health Administration	$3.2	6.9%	$3.4	6.9%	$3.8	6.6%	$4.0	6.6%	$4.3	7.0%
Bureau of Community and Environmental Health	$2.3	5.0%	$2.3	4.7%	$2.9	5.0%	$2.9	4.8%	$3.4	5.5%
Administration	$0.5	1.1%	$0.4	0.8%	$0.4	0.7%	$0.4	0.7%	$0.4	0.7%
Governor's Council (on adolescent pregnancy prevention)	$0.3	0.6%	$0.4	0.8%	$0.3	0.5%	$0.7	1.1%	$0.8	1.3%
Total	$46.2	100.0%	$49.3	100.0%	$57.8	100.0%	$60.9	100.0%	$61.4	100.0%

Source: Idaho Department of Health and Welfare.
Notes: See Table 22 for more information on individual activities.

Table 24 shows DHW's physical health expenditures by activity during FYs 2002-2006. (See more information in Table 22 above for what each of these activities includes.) Preventive services made up the largest share of physical health expenditures, followed by vital statistics and public health preparedness. DHW administration under this area and the Governor's Council on adolescent pregnancy prevention comprised the smallest share of physical health care expenditures (less than $1.0 million each). Expenditures increased across all physical health budget activities with the exception of DHW administration, which held steadily at or below $500,000 per year. While the proportion of total physical health expenditures attributable to preventive services and administration decreased between FYs 2002 and 2006, the relative shares of spending for vital statistics/health preparedness and the Governor's Council grew. In fact, the proportion of total spending dedicated to vital statistics/health preparedness nearly doubled since FY 2002.

Table 25. Idaho's Department of Health and Welfare: Substance Abuse Expenditures by Activity (FY 2002-2006)

	2002		2003		2004		2005		2006	
Activity	(millions)	%	(millions)	%	(millions)	%	(millions)	%	(millions)	%
Treatment	$8.4	70.6%	$7.9	61.2%	$8.8	62.4%	$8.4	62.2%	$12.8	69.9%
Prevention	$2.2	18.5%	$2.5	19.4%	$2.7	19.1%	$2.3	17.0%	$2.3	12.6%
Administration	$0.5	4.2%	$0.5	3.9%	$0.6	4.3%	$0.6	4.4%	$0.8	4.4%
Drug Courts	$0.4	3.4%	$1.4	10.9%	$1.7	12.1%	$1.9	14.1%	$2.0	10.9%
Youth Tobacco Account	$0.4	3.4%	$0.6	4.7%	$0.4	2.8%	$0.3	2.2%	$0.3	1.6%
Total	$11.9	100.0%	$12.9	100.0%	$14.1	100.0%	$13.5	100.0%	$18.3	100.0%

Source: Idaho Department of Health and Welfare.

Notes: See Table 22 for more information on individual activities.

Table 25 shows DHW's substance abuse expenditures by activity during FYs 2002-2006. Substance abuse treatment services made up the largest share of these expenditures, followed by prevention services. More recently, administration and the Youth Tobacco Account (e.g., tobacco inspections) have comprised the smallest share of DHW's substance abuse expenditures (less than $1.0 million each). Between FY 2002 and 2006, expenditures increased across the substance abuse budget activities except for prevention and the Youth Tobacco Account. In fact, prevention's share of total expenditures decreased by 31.9% from 18.5% to 12.6% during the five years. In contrast, treatment's role in total expenditures has expanded since FY 2003. Administration expenditures grew slightly between FYs 2002 and 2006, from approximately $500,000 to $800,000, representing an increase of 60%.

Table 26. Idaho's Department of Health and Welfare: Children's Mental Health Expenditures by Activity (FY 2002-2006)

Activity	2002		2003		2004		2005		2006	
	(millions)	%	(millions)	%	(millions)	%	(millions)	%	(millions)	%
Family Clinical Services	$10.2	85.0%	$10.0	83.3%	$9.7	66.0%	$9.5	60.9%	$11.3	60.1%
Foster Care	$1.3	10.8%	$1.7	14.2%	$4.2	28.6%	$4.6	29.5%	$5.2	27.7%
Idaho Council on Children's Mental Health	$0.2	1.7%	$0.1	0.8%	$0.2	1.4%	$0.2	1.3%	$0.2	1.1%
Block Grant Special Projects	$0.2	1.7%	$0.0	0.0%	$0.1	0.7%	$0.2	1.3%	$0.3	1.6%
Children's Mental Health Initiative	$0.1	0.8%	$0.1	0.8%	$0.6	4.1%	$1.1	7.1%	$1.2	6.4%
Child Clinical Receipts	$0.0	0.0%	$0.1	0.8%	$0.0	0.0%	$0.1	0.6%	$0.1	0.5%
Administration	--	--	--	--	--	--	--	--	$0.4	2.1%
Total	$12.0	100.0%	$12.0	100.0%	$14.7	100.0%	$15.6	100.0%	$18.8	100.0%

Source: Idaho Department of Health and Welfare.

Notes: Prior to FY 2006, children's mental health services were organized under another DHW administrative unit. Administrative costs are therefore not reported for FY 2002-2005. See 22 for more information on individual activities.

Table 26 presents DHW's expenditures on children's mental health by activity during FYs 2002-2006. Family clinical services comprised the largest share of these expenditures, followed by mental health services for children placed in foster care. In fact, all other expenditure activities (including the state and regional councils on children's mental health, child clinical receipts) involve a relatively minor level of expenditure. Between FY 2002 and 2006, children's mental health expenditures increased, except those for state and regional councils on children's mental health, which recorded $200,000 in expenditures most years. Over time, family clinical services have represented a smaller proportion of overall spending (down to 60.1% in FY 2006 from 85.0% in FY 2002), whereas the role of mental health services for children in foster care and the Children's Mental Health Initiative in overall expenditures grew. It is not possible to isolate administration expenses associated with DHW's children's mental health expenditures for FYs 2002-2005 because these services were organized under another DHW administrative unit during that time. In FY 2006, administration expenses amounted to approximately $400,000, or about 2.1% of DHW's total children's mental health expenditures.

Table 27. Idaho's Department of Health and Welfare: Adult Mental Health Expenditures by Activity (FY 2002-2006)

Activity	2002 (millions)	2002 %	2003 (millions)	2003 %	2004 (millions)	2004 %	2005 (millions)	2005 %	2006 (millions)	2006 %
Base Program Services	$15.6	83.9%	$14.4	87.8%	$14.7	82.1%	$15.3	82.3%	$14.7	77.5%
Community Hospitalization	$1.2	6.5%	$0.8	4.8%	$1.5	8.6%	$1.6	8.8%	$0.0	0.0%
Mental Health Bureau	$0.7	3.9%	$0.5	3.2%	$0.9	4.9%	$0.6	3.3%	$0.6	3.3%
Projects for Assistance within Transition from Homelessness Program	$0.4	1.9%	$0.4	2.2%	$0.5	2.6%	$0.3	1.8%	$0.4	1.9%
MH Sheltered Workshops	$0.3	1.6%	$0.2	1.5%	$0.2	1.4%	<$0.1	0.0%	$0.0	0.0%
Regional Program Support	$0.3	1.8%	<$0.1	0.2%	<$0.1	0.2%	<$0.1	0.2%	<$0.1	0.2%
Housing Services/Insurance	$0.1	0.3%	$0.1	0.3%	<$0.1	0.3%	<$0.1	0.1%	<$0.1	0.1%
Psychosocial rehab services authorization/audits	$0.0	0.0%	$0.0	0.0%	$0.0	0.0%	$0.6	3.5%	$1.0	5.1%
Assertive Community Treatment	$0.0	0.0%	$0.0	0.0%	$0.0	0.0%	$0.0	0.0%	$2.2	11.9%
Total	$18.6	100.0%	$16.4	100.0%	$17.9	100.0%	$18.6	100.0%	$18.9	100.0%

Source: Idaho Department of Health and Welfare.
Notes: See Table 22 for more information on individual activities. Columns may not total 100.0% due to rounding.

Finally, Table 27 breaks down DHW's adult mental health expenditures by activity for FYs 2002-2006. Base program services (including consumer/family support and advocacy, facility maintenance/improvements, the state's planning council, and data collection/infrastructure) consistently proved to be the most expensive area of spending, representing 77.5% of total adult mental health expenditures in FY 2006 (this percentage is down from 87.8%, however, in FY 2003). In FY 2006, $2.2 million was spent (representing 11.9% of total expenditures) on the Assertive Community Treatment team providing intensive community services for adults with mental illness. Also in FY 2006, authorizations and audits for psychosocial rehab services accounted for 5.1% of DHW's adult mental health expenditures.

Highlights – Public Health Services

- Between FYs 2002 and 2006, state/federal public health services expenditures (including DHW and public health districts) grew from $114.2 to $143.9 million, representing an increase of 26.0% overall. Since FY 2003, state general funds have consistently supported about a third of these public health expenses. The share of expenses supported by federal and state dedicated funds fluctuated somewhat during the five years, with federal funds representing the largest share (at least 43.4%) since FY 2003 and state dedicated funds covering the remainder (19.9% in FY 2006).
- Between FYs 2002 and 2006, direct state appropriations for regional public health districts held consistently at approximately $10 million per year. No federal dollars were directed to public health districts by the state.
- Within DHW's Divisions of Public Health and Behavioral Health, public health expenditures (including both federal and state dollars) increased noticeably between FYs 2002 and 2006 across the areas of physical health, emergency medical services, substance abuse services, children's mental health, and community hospitalization. Expenditures for adult mental health fluctuated little during this five-year time span.
- State funding for DHW's public health services grew between FYs 2002 and 2006, especially for physical health services (from $14.4 to $17.3 million, or 19.8%).
- Federal funding for DHW's public health services also increased over the years (except for adult mental health) and grew particularly for physical health services (from $31.8 to $44.1 million, or 38.6%) and substance abuse services (from $6.2 to $13.8 million, or 122.8%).

OTHER PROGRAMS: STATE HEALTH CARE-RELATED TAX EXPENDITURES

STATE HEALTH CARE-RELATED TAX EXPENDITURES

Program Description

Tax expenditures or tax breaks are departures from the broad tax base, which consists of income and sales taxes, both of which contribute over 90% of the state general fund revenue for Idaho. These departures from the tax base can be in the form of exemptions, credits, exclusions or deductions and are used to either encourage a certain behavior, provide fiscal relief to certain taxpayers, or ease the administration of tax laws. For the purposes of this report, we focus on two of Idaho's individual income tax health care-related deductions—the Health Insurance deduction, and the Medical Savings Account (MSA) deduction.

Under Idaho Code §63-3022P, health insurance-related payments (which include hospitals, dental, vision or other benefits) incurred by the taxpayer or dependents in the taxable year can be deducted for Idaho income tax purposes from taxable income, so long as the premium amounts have not already been deducted or excluded from income.[27] Employers are required to provide a statement to employees showing whether the employee contribution for health insurance has been deducted from the employees' taxable income. This health insurance deduction was put into effect in 2000 for self-employed persons and later amended in 2001 to include all persons.

Under Idaho Code §63-3022K, any contributions made to a MSA, which is used to pay for eligible medical expenses incurred by the account holder or eligible dependents, can be deducted from taxable income by the account holder. However, if the MSA monies are withdrawn for reasons other than eligible medical expenses, they are subject to Idaho tax. Individuals under 59 ½ years of age who withdraw MSA monies subject to tax also are penalized 10% of the amount withdrawn, which has to be declared on the individual's state income tax return.[28] Among other restrictions, this deduction is capped at $2,000 per individual (per spouse on joint returns), and any interest earned on this account is deductible as well. MSAs commenced in 1995 to eliminate high-deductible insurance policies and provide options for taxpayer-funded accounts.[29,30]

If health insurance premium payments are made from MSAs, they are not eligible for a deduction since they are likely to have been accounted for and deducted from the taxable income.[31]

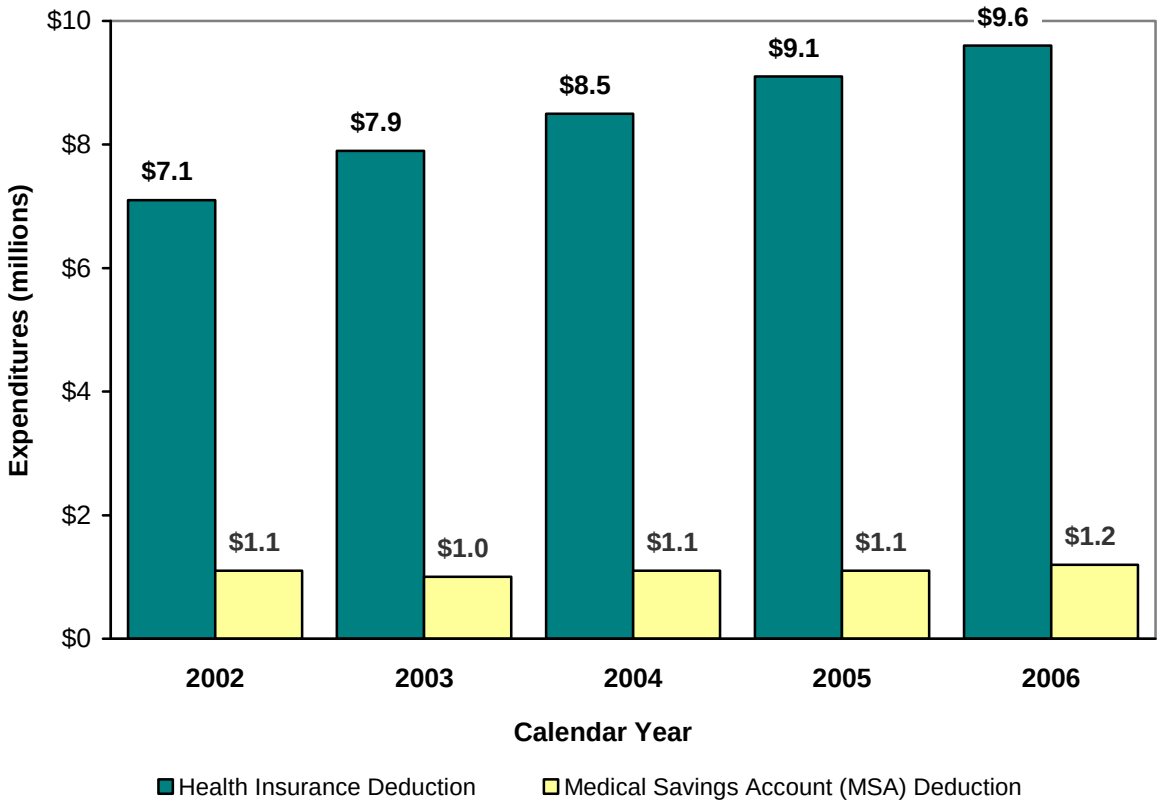
Data Sources

Data on tax expenditures for CYs 2002-2006 are available from the General Fund Revenue Books prepared by the Idaho Division of Financial Management. Data presented below are estimates of the amount of tax payment avoided by the beneficiaries of these deductions. However, it is important to note that they are <u>not</u> an estimate of the state's forgone tax revenue had the deduction been eliminated. Not captured in these estimates are the overhead costs that would be incurred by the state to collect the forgone revenue or the 'tax gaps' – i.e., the difference between the amount of revenue that would have been realized in the absence of the deductions and the actual amount of revenue that would have been raised. The size of the difference

depends on factors such as the mechanisms used to remove the deductions and resources allocated to monitor compliance and collection efforts.

Findings

Figure 43. Idaho's Tax Expenditures: Health-Related Tax Deductions (CY 2002-2006)



Source: Data for CY 2002 are from the General Fund Revenue Book: FY 2007 Executive Budget. Data for CY 2003-2006 are from the General Fund Revenue Book: FY 2008 Executive Budget.

Notes: Health Insurance Deduction refers to pre-tax health care-related payments such as premiums. MSA Deduction refers to pre-tax contributions made for eligible medical expenditures.

Between CYs 2002 and 2006, deductions taken by Idaho residents for health insurance increased by 36.0% to $9,620,000. The largest annual increase (11.7%) was between CYs 2002 and 2003. Compared to the health insurance deductions, growth in the MSA deductions was slower (15.4%). Between CY 2002 and 2003, a slight decline in MSA deductions was witnessed, but since that time, these deductions have experienced a modest increase, and as of CY2006, totaled $1,212,000.

Highlights –Tax Expenditures

- State tax expenditures associated with both the individual health insurance deduction and MSA deduction increased between CYs 2002 and 2006. Whereas the MSA deductions increased by about 15.4%, the health insurance deductions grew by 36.0%. In 2006, these tax expenditures combined totaled $10.8 million.

SUMMARY AND LESSONS LEARNED

This report is one out of a series of reports prepared for the Idaho JLOC, Health Care Task Force, and OPE as part of the project, "Idaho's Health Care Costs and Options to Improve Health Care Access." The Idaho Health Care Task Force requested that this project be conducted to generate information on health care spending, the uninsured, and various policy approaches as the Task Force considers options for expanding health insurance coverage and health care access in the state. The Idaho Legislature (Senate Bill 1340) appropriated funds for the project in 2006.

This report presents a study of public health care expenditures in Idaho between 2002 and 2006. The purpose of the study was to systematically collect and organize data on and quantify federal, state, and local government health care expenditures in the state. The report covers 13 areas of public health care expenditure organized into five broader categories of spending:

- Medicare
- Medicaid/CHIP
- Public employee health benefits (state and local government)
- Safety net programs (state and county medical indigent care, Idaho's individual high risk reinsurance pool, community health centers)
- Other health care spending (correctional health care expenditures, public health service expenditures, and select tax expenditures on health care-related deductions)

Where possible, the study collected information about funding sources, enrollment, health care expenditures (by diagnosis and service type), as well as administrative expenses associated with each program across these areas of public health care spending. The expenditures presented in the report were not adjusted for inflation.

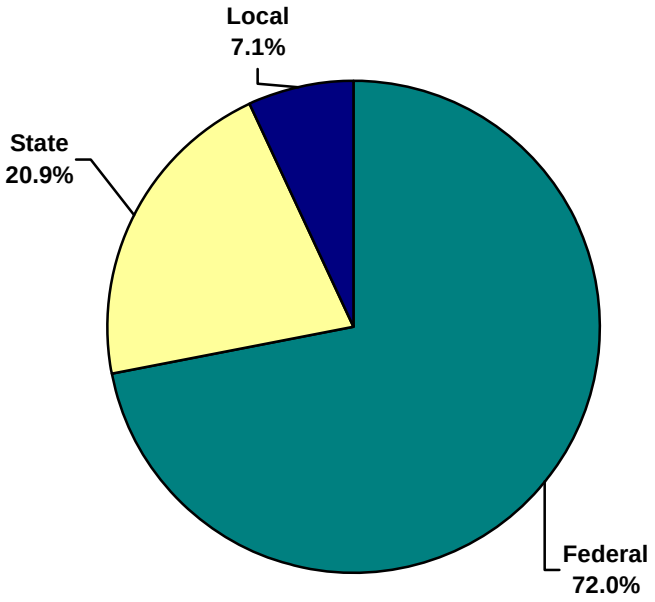
This final section of the report provides an overview of findings, reviews study strengths and weaknesses, and provides recommendations for the compilation of Idaho's public health expenditure data in the future. Our summary of findings aggregates the program-specific data presented throughout the body of the report to provide a broad picture of the distribution and composition of public health care spending in Idaho at the federal, state and local levels as well as public health care spending in Idaho across the five categories of programs. To simplify this summary of results, we focused on available data for the most recent years, 2005 (in the context of Medicare) and 2006 (for all other programs). As already mentioned, we attempted to collect data from all programs on a state fiscal year basis, but some of the programs were not able to furnish data for this time frame and instead provided data for calendar year or county fiscal year. Our aggregation of program-specific data therefore necessitated blending these various time frames.

Overview of Findings for Idaho

Public Health Care Spending in Idaho by Federal, State, and Local Funds

Taking into consideration all of the public programs addressed in this report, public health expenditures in Idaho totaled $2.6 billion in 2005. As shown in Figure 44, federal funds totaled nearly $1.9 billion and constituted the majority (72.0%) of the $2.6 billion in public health care spending in Idaho in 2005. State dollars supported just over a fifth of public spending ($544.7 million), followed by local government funds ($183.7 million or 7.1%).

Figure 44. Public Health Care Spending in Idaho by Level of Government (2005)



Total Public Expenditures: $2.6 billion

Notes: Based on the 13 federal, state, and local areas of public health care spending addressed in this report: Medicare; Medicaid/CHIP; state, county, city, school district employee health benefits; state and county medical indigent care; Idaho's Individual High Risk Reinsurance Pool; community health centers; state adult and juvenile and county corrections health care; public health services; and select health care-related tax expenditures.

Federal funds supported the following programs in the state: Medicare, Medicaid/CHIP, public health services, and community health care centers. In 2005, just over half (55.4%) of federal public health care spending in Idaho was directed to Medicare. Medicaid/CHIP represented another 40.4% of federal spending in the state. Public health service expenditures and federal

grants to community health centers (CHCs) comprised relatively minor shares of federal spending (3.3% and 0.9%, respectively) in Idaho.

Within Idaho, state funds supported Medicaid/CHIP, state employee/retiree health benefits, the state Catastrophic Health Care Cost Program, the high risk reinsurance pool, CHCs, adult and juvenile corrections medical care, public health services, and tax expenditures. In 2006, over half (56.3%) of state public health care spending was on Medicaid/CHIP, followed by 22.1% for state employee/retiree health benefits and 13.0% for public health services. The State Catastrophic Program, adult corrections, and tax expenditures on health care-related deductions made up significantly smaller shares of state spending. Juvenile corrections, the Idaho Individual High Risk Reinsurance Pool, and CHCs made up less than 1.0% of state spending on health care in Idaho.

Local government funds were used for local public employee health benefits, the counties' indigent medical indigency programs, county corrections medical care, and CHCs in the state. The majority (87.6%) of local public health care spending in 2006 was for public employee health benefits. The county medical indigency program ($16.1 million or 7.9%), county jail medical expenses ($9.1 million or 4.5%), and CHCs ($0.2 million or < 1.0%) made up the remainder of local public health care spending addressed in this report.

Public Health Care Spending in Idaho across Main Program Areas

This report examines five categories of public health care spending in Idaho: Medicare, Medicaid/CHIP, public employee health benefits, safety net programs, and other public health care expenditures. Figure 45 (below) shows the distribution of expenditures by spending category.

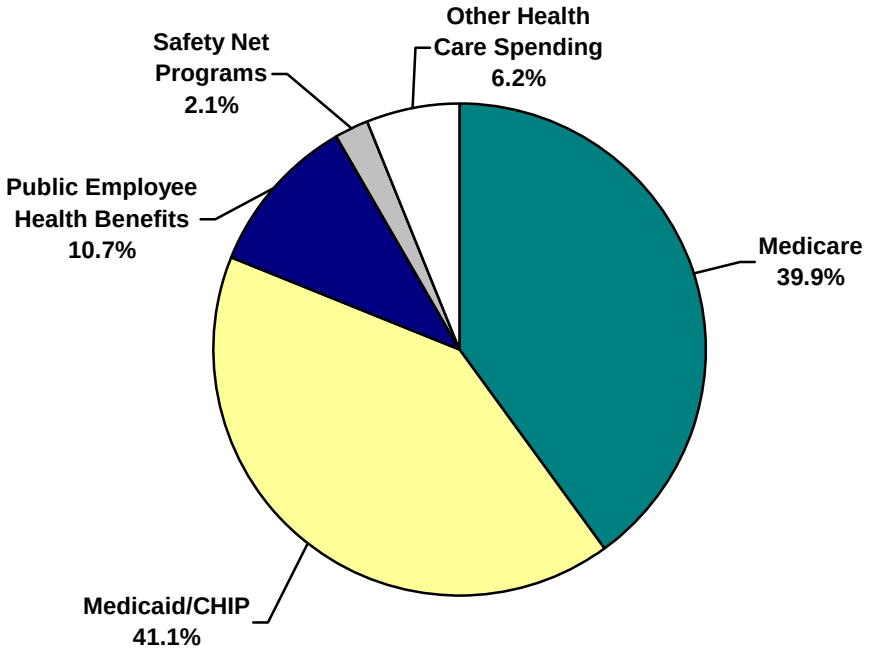
Of the $2.6 billion in total public health care spending in Idaho, Medicaid/CHIP ($1.1 billion) and Medicare ($1.0 billion) comprised the majority of public health care spending in the state (each at approximately 40%) in 2005. Public employee health benefits (state and local combined) amounted to $278.7 million (representing another 10.7%), followed by $161.4 million (or 6.2%) in other public health care spending and $53.9 million (or 2.1%) for safety net programs.

In 2006, local employee/retiree benefits (i.e., city, county, and school district) comprised the slight majority of overall public employee/retiree health benefit spending ($178.7 million or 57.8%), whereas state employee benefits cost the state $130.4 million. The data we obtained for local government employee health benefits overestimate the government share of these expenditures because they include both the employer's and employee's share of the premiums. On the other hand, the data likely underestimate local government employee health benefit expenditures in that they do not incorporate administrative expenses associated with the plans.

Regarding public health care safety net expenditures, the state Catastrophic Program totaled $20.4 million in 2006, making up 34.8% of the total public health care safety net spending in the state. Considering county medical indigency program expenditures ($16.1 million, or 27.4% of total safety net expenditures), medical indigent care totaled $36.5 million, representing over half

(62.2%) of the total public health care safety net expenditures in the state. Although CHCs are a minor player in overall public health care spending in Idaho, they made up another important component of public safety net expenditures. In 2006, their non-patient-related federal and state dollars ($19.8 million) represented a third of total safety net spending. The state's spending on the high risk reinsurance pool ($2.4 million) contributed the smallest share (4.1%) of public safety net spending. (Note: The CHC and high risk pool expenditures presented in this report only pertain to public dollars. Private dollars are not included.)

Figure 45. Public Health Care Expenditures in Idaho by Spending Category (2005)



Total Public Expenditures: $2.6 billion

Notes: Based on the 13 federal, state, and local areas of public health care spending addressed in this report organized into five categories: 1) Medicare; 2) Medicaid/CHIP; 3)public employee health benefits (state, county, city, school district employee health benefits); 4) safety net programs (state and county medical indigent care, Idaho's Individual High Risk Reinsurance Pool, community health centers); and 5) other public health care spending (state adult and juvenile and county corrections health care, public health services, and select health care-related tax expenditures).

Finally, at $143.9 million, public health services dominated (79.9%) the category of other public health care spending in Idaho in 2006. Correctional health care (including both state and county, adult and juvenile) resulted in another 14.2% of spending. The majority of corrections medical expenditures was associated with adult state prisoners. Tax expenditures on the health insurance and Medical Savings Account (MSA) deductions contributed another $10.8 million or 6.0% to other public health care spending in Idaho.

Study Strengths and Limitations

A key advantage to the design of the study presented in this report is its breadth. This report compiles, organizes, and summarizes a great deal of data on a full range of public health expenditures into one resource for OPE and state legislators. Compared to commonly-referenced national sources (such as the CMS State Health Expenditure Accounts and NASBO State Health Expenditure Reports) and initiatives undertaken by other states to catalog public health care costs (e.g., Maryland[32]), this study on public health care expenditures in Idaho is unique for its attention to expenditures at a local level – i.e., by counties, school districts, and cities. Another strength of the study presented in this report is the longitudinal data it collected.

Nonetheless, there are disadvantages associated with the wide scope of this project. First, given the broad interests of the Health Care Task Force and the timeline and resources allocated to the project, this study does not afford an in-depth examination of the expenditures associated with any one program. It is also important to note that, while this report considers a variety of public health care expenditures, still not all public care expenditures were considered in the scope of the project. Examples of other public health care costs that were not addressed are federal employee health care benefits, Medicare's disproportionate share hospital (DSH) and graduate medical education (GME) funding, public dollars on long term care (other than Medicaid), and county government funding for the public health districts in the state.

Finally, as is evident by the sheer amount of data presented in this report, there are a number of resources available within Idaho offering data to better understand public health care expenditures in the state. Nonetheless, as with all data collection efforts (especially those taking advantage of existing administrative data), we inevitably encountered limitations to the data. These include:

- **Types of data available and accessible**. While every effort was made to collect data on funding sources, enrollment, health care expenditures (by diagnosis and service type), as well as administrative expenses for each area of public health care spending and for the years 2002-2006, not all of these data were available. There are a number of reasons for this: Administrative data systems associated with a program may not include all of these items or may store them in inaccessible ways; data systems may be antiquated and/or have been revised and do not contain consistent data for multiple years or only contain more recent data; programs/organizations may not be mandated to collect and track certain types of data; and data are available but not accessible for research purposes due to their proprietary nature (in the case of contract program administrators or private carriers). Additionally, data for smaller programs may be limited due to concerns about information privacy. Some of these reasons are even more pronounced at the local level.

- **Inconsistency in data**. Related to the above point is that there are differences in the ways in which programs measure and track health care program enrollment and expenditures. Further, while many programs at a state level monitor data on a state fiscal year basis, counties and school districts likely negotiate health plans, for example, on a county fiscal school year basis. For these reasons, standardized data across programs was an unrealistic

aim. Hence, while uniformity across program categories was requested to the extent possible, the data received varied considerably according to the programs and the nature of available data.

- **Time required for data collection**. Although all of the data collected for this study was based on existing program administrative data (and did not involve primary data collection), obtaining these data and compiling them proved to be time- and resource-intensive. Thorough efforts to catalog state public health care expenditures can take more than a year to accomplish. The importance of research staff becoming familiar with the formatting and availability of program data in preparing data requests, the time for program staff to pull data from data warehouses and/or conduct ad hoc analyses, competing demands on program staff, the need for non-public entities to obtain internal approval to furnish data, and the desire to coordinate requests with Blue Cross of Idaho and Regence Blue Shield of Idaho were all factors in the time required to compile the data presented in this report. Further, our data requests coincided with the end of the 2007 legislative session and SFY 2007, both of which also caused some delays in data delivery.

Recommendations

As the Idaho Health Care Task Force recognized in requesting this study, having up-to-date and complete data on public health care expenditures is important for informed decision making by policy makers. It is important to acknowledge, however, that the collection and analysis of such data are a time- and resource-intensive process. A key consideration in conducting such an initiative (and maintaining one over time) is to establish policy information needs and priorities. Criteria that may be used to determine the scope of future data compilation efforts in Idaho include:

- Are there areas of public health care spending with particular relevance to current legislative goals?

- What are the areas of public health care spending over which policy makers have more control? (For example, for state policy makers, is detailed expenditure information concerning state programs the most important?)

- What is each public program's/entity's estimated role in public health care spending? (For example, how important are detailed data on low-expenditure programs such as juvenile corrections health care?)

- Where do key public health expenditure information gaps exist? (For example, if of particular interest, local government employee health benefits may warrant further examination.)

- What level of information is needed? (Is there a need for basic information about a broad set of public health care programs or in-depth information for a select set of spending areas?)

- What is the feasibility of obtaining and analyzing certain health care expenditure data?

Yet another consideration in the future monitoring of public health care expenditures in Idaho is the availability and accessibility of data. Successful tracking of health care spending requires accurate and efficient information tracking capabilities and obtainable reporting. The availability and accessibility of data from state agencies, local agencies, and private stakeholders should be considered. As indicated several times throughout this report, smaller units of government especially may not be fully automated, may not have easy access to past data, and may not be able to report data in a consistent manner. Further, even when data are available, contractors may have concerns about sharing information that could be considered proprietary in nature. Reporting patterns and requirements of state, local, and private parties should be considered.

A final consideration in the future monitoring of public health care expenditures in Idaho is the scheduling of such an effort. As stated already, thorough efforts to catalog state public health care expenditures take time to accomplish. This project collected *existing* data over a six and ½ month period yet obtaining all requested information still proved difficult for the reasons listed above. The time requirements of and information gains from collecting primary vs. secondary (existing) data should be weighed and considered in light of the state's future information priorities.

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NOTES

[1] Because NASBO's State Health Expenditure Reports contain data through 2003 only, we trended this data to 2004. State health care expenditures for each spending area as presented in the NASBO 2002-2003 report were individually estimated assuming the same rate of change for the year 2004. These estimates were aggregated to estimate the total state health care expenditure for 2004 and the percent share of expenditure for each spending area in the same year.

[2] Idaho's state fiscal years run July 1-June 30. FY dates represent the year in which the fiscal year ended. Therefore, FY 2006 refers to July 2005-June 2006.

[3] See U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group (2007d).

[4]See U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group (2007b).

[5] See U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group (2007b).

[6] See Kaiser Family Foundation (2005).

[7] The FMAP refers to the federal government's share of each state's Medicaid and CHIP programs. The match rate is calculated annually based on a formula that takes into account a state's average per capita income level. States with lower income levels (including Idaho) are reimbursed at a higher rate. For more information, see http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp

[8] See U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS), Health Care Information System (HCIS) (2005).

[9] See U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS), Medicare Beneficiary Data System (2005).

[10] See U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS), Medicare Beneficiary Data System (2005).

[11] See U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group (2007c).

[12] See Kaiser Family Foundation (2006c).

[13] See Kaiser Family Foundation (2006a).

[14] See Kaiser Family Foundation (2007b).

[15] Or those who work 84 hours/month and are expected to work at least 5 months during a 12-month consecutive period.

[16] The regular retirement allowance must equal or exceed the single retiree premium rate or the individual must have at least 10 years or 20,800 hours of credited state service.

[17] Based on SHADAC's analysis of local government employee health plan information compiled by Idaho Office of Performance Evaluations.

[18] See Idaho Department of Insurance (2006).

[19] See Communicating for Agriculture and the Self-Employed (2005).

[20] See Idaho Primary Care Association (2007b).

[21] The maximum age of custody is 19 years, unless extended time in custody is recommended by IDJC Custody Review Board. IDJC has committed juveniles as young as 10 years old, but no juvenile is to remain in custody past their 21st birthday.

[22] See Idaho Department of Juvenile Corrections (2007b).

[23] See Idaho Legislative Services Office (2007b). Idaho Code §20-601. Available at http://www3.state.id.us/cgi-bin/newidst?sctid=200060001.K

[24] See Idaho Legislative Services Office (2007b). Idaho Code §20-619. Available at http://www3.state.id.us/cgi-bin/newidst?sctid=200060019.K

[25] See Idaho Legislative Services Office (2007b). Idaho Code §20-619. Available at http://www3.state.id.us/cgi-bin/newidst?sctid=200060019.K

[26] Personal Communication with Pamela Collette, Ada County Sheriff's Office.
[27] See Idaho Legislative Services Office (2007b). Idaho Code §63-3022P. Available at http://www3.state.id.us/cgi-bin/newidst?sctid=630300022P.K
[28] See Idaho State Tax Commission (2007).
[29] See Idaho Legislative Services Office (2007b). Idaho Code §63-3022K. Available at http://www3.state.id.us/cgi-bin/newidst?sctid=630300022K.K
[30] See Idaho Division of Financial Management (2006).
[31] See Idaho State Tax Commission (2007).
[32] See Maryland Health Care Commission (2007).

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